Clinical Questionnaire

Question	Answer
1) When was your last visit to the dentist?	_______
2) When was your last comprehensive exam and full set of X-rays?	_______
3) When was your last dental cleaning?	_______
4) How often do you see a hygienist for dental cleanings?	3-4-6
5) Do you use a hard, medium, or soft toothbrush?	_______
6) Do your gums feel swollen or bleed?	Yes/No
7) Have you ever seen a periodontist?	Yes/No
8) Do you have any relatives with periodontal disease	Yes/No
9) Do you have a problem with Halitosis?	Yes/No
10) Do you feel like you have a dry mouth?	Yes/No
11) Do you have any concerns about the appearance of your teeth?	Yes/No
12) Are you interested in a whiter and brighter smile?	Yes/No
13) Do you have any broken teeth that you know of?	Yes/No
14) Are you experiencing any discomfort or pain on your teeth now?	Yes/No
15) Do you have any pain in any teeth while biting or chewing?	Yes/No
16) Does food catch between any specific teeth and cause discomfort?	Yes/No
17) Do you avoid any part of your mouth while brushing or or flossing your teeth?	Yes/No
18) Have you ever had any teeth removed?	Yes/No
19) Are you experiencing any tenderness in the muscles surrounding your mouth?	Yes/No
20) Have you noticed any soreness in your jaw?	Yes/No
21) Are you in the habit of biting your nails or any other hard object?	Yes/No
22) Has anyone made you aware of clenching or grinding your teeth during the day or night?	Yes/No