

Dental History Questionnaire

What is the primary reason for your visit today? _____

What would you like to change in your smile? _____

Pain history:

Do you have:

YES NO

- Oral pain now?
- Chronic oral-facial or headache pain?
- Pain when you open or close your mouth?
- Popping or clicking in your jaw?
- Do you grind/clench your teeth?

Saliva:

YES NO

- Does the amount of saliva in your mouth seem to be too little?
- Does your mouth feel dry when eating a meal?

Dental treatment history:

What was the date of your last dental visit? _____

What treatment was rendered at that visit? _____

Periodontal disease history:

YES NO

- Have you ever been told that you have periodontal (gum) disease?
- Do your gums bleed?
- Have you noticed your gums receding?
- Have you ever received treatment for periodontal (gum) disease?

If so, what type?

Scaling and root planing (deep cleaning): _____

Periodontal surgery: _____

Bone graft: _____

Gum graft: _____

Dental Implants: _____

Anxiety:

YES NO

- Have you ever had a bad experience at the dental office?

How do you feel about receiving dental treatment?

- Very relaxed
- A little uneasy
- Moderately anxious
- Very anxious

Name _____ Date _____