Dental history questionnaire for: ______________________________

What brings you to our office today?_________________________________

____

Are you having any discomfort at this time? ___Yes ___No If yes, Please explain ____

Do you have any missing teeth? ___Yes ___No If yes, have they been replaced?____

Are your teeth sensitive? ___Yes ___No To what?______________________

Describe your usual hygiene routine at home___________________________

____

Do your gums ever bleed? ___Yes ___No with Brushing___ Flossing___

Do you clench or grind your teeth? ___Yes ___No

Does food ever get wedged between your teeth? ___Yes ___No

Does your jaw ever pop, click or hurt? ___Yes ___No

Do you ever have headaches? ___Yes ___No How often? _______________

What part of your head?____

Have you had gum treatments? ___Yes ___No

If yes, please explain ____

Have you had braces or any other dental treatment? ___Yes ___No

If yes, please explain____

Do you feel you may have bad breath? ___Yes ___No

Do you smoke cigarettes? ___Yes ___No Packs per day?___ How long?___

Do you drink alcoholic beverages? ___Yes ___No

Do you have any fear of dentistry? ___Yes ___No

What do you feel the overall condition of your mouth is?_________________

____

What is the purpose, in your viewpoint, of going to the dentist routinely?____

Have you ever had an unpleasant dental experience? ___Yes ___No

What do you want to see your teeth and your smile 20 years from now?

____

____

Is there anything else we should know about you?_____________________

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