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Cosmetic and Implant Questionnaire

Patient Name: _____ Date: _____

Please answer the following completely and thoroughly (use extra paper if needed):

1) What do you want to hear at your consultation visit with Dr. Hughes?

2) What is the most important thing you want to see in yourself when your dental care with Dr. Hughes is completed?

3) What specifically happened to you that got you to call Dr. Hughes?

4) What do you feel is your main dental problem? What do you feel is wrong?
When did it start and how long have you suffered?

5) Rate how much your dental problem effects you in each area (1 = no effect at all, 10 it effects me very much):
Pain:____ Embarrassment: ____ Eating Difficulty: ____ Ability to Smile: ____

6) Please list everything you have done or tried that has not worked:

7) Why do you believe right now is the time to get your problems fixed?

8) How are your dental problems affecting your everyday life?

9) If you have (circle) dentures or partials? How long have you had them? Do you wear them every day and all of the time?

10) Please tell us about any dental experiences that are upsetting to you?

DO YOU FEEL/BELIEVE YOU SUFFER FROM THESE EFFECTS OF MISSING AND FAILING TEETH? (Check all that apply to you.)

___Avoid eating in public.

___Avoid being seen in public.

___Pain upon chewing.

___Anxiety about your Smile.

___Difficulty in dealing with stress.

___Social Embarrassment

___Difficulty in Sleeping.

___Difficulty swallowing

___Change in foods you eat.

___Altered taste of food.

- | | |
|---|--|
| <input type="checkbox"/> Face falling in | <input type="checkbox"/> Nutritional Disorders |
| <input type="checkbox"/> Inconvenience | <input type="checkbox"/> Loss of support for the face. |
| <input type="checkbox"/> Shrinking bone | <input type="checkbox"/> Must use denture adhesive (Upper) |
| <input type="checkbox"/> Must use denture adhesive (Lower) | <input type="checkbox"/> Ill fitting or unattractive partials. |
| <input type="checkbox"/> Gag Reflex | <input type="checkbox"/> A need to feel whole again. |
| <input type="checkbox"/> Bad breath that will not go away. | <input type="checkbox"/> Feel older than you are. |
| <input type="checkbox"/> Loss of Self Esteem | <input type="checkbox"/> Teeth do not look real. |
| <input type="checkbox"/> Unattractive smile | <input type="checkbox"/> Difficulty Chewing |
| <input type="checkbox"/> Mouth Sores | <input type="checkbox"/> Difficulty Speaking |
| <input type="checkbox"/> Unstable dentures | <input type="checkbox"/> Burning sensations |
| <input type="checkbox"/> Unnatural Feel | <input type="checkbox"/> Limitations of foods that can be eaten. |
| <input type="checkbox"/> Ashamed to smile | <input type="checkbox"/> Increased Wrinkles |
| <input type="checkbox"/> Shrinking gums | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Numbness in face and lips. | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Withdrawal from social interaction. | <input type="checkbox"/> Food trapped between/under your teeth. |
| <input type="checkbox"/> Dizziness or Ringing in the ears. | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Teeth are unsightly. | <input type="checkbox"/> Teeth move so much, I do not wear them. |
| <input type="checkbox"/> Avoid certain foods. | <input type="checkbox"/> Avoid foods I would like to enjoy. |
| <input type="checkbox"/> Teeth are uncomfortable. | <input type="checkbox"/> Jaw is sore. |
| <input type="checkbox"/> Depressed/insecure about loss of teeth. | |
| <input type="checkbox"/> Previous Bad Dental Experiences | |
| <input type="checkbox"/> I chew better without my dentures/partial. | |

___Difficulty in dating relationships or sex life because of your teeth.

___Difficulty adjusting to life without your own teeth.

Please rank each of the following problems and how they will influence whether you get your dental treatment completed:

1 = Will not prevent me from getting my dental treatment.

5 = Will likely prevent me from getting my dental treatment.

The COST of treatment.....1 2 3 4 5

My FEAR of the dentist.....1 2 3 4 5

My lack of TIME..... 1 2 3 4 5

I have UNREALISTIC EXPECTATIONS.....1 2 3 4 5

I have been involved with a legal claim or lawsuit involving a medical/dental provider. Circle (Yes) (No)

Patient Signature_____Date_____

***** FOR DOCTOR HUGHES' USE ONLY*****

PROBLEMS:_____

Results of Consultation:_____

Notes:_____

___DENIED (WILL NOT BENEFIT)

___ACCEPTED (WILL BENEFIT)

