DENTAL QUESTIONNAIRE

NAME: _____ DATE: _____

YES	NO	QUESTIONS:
[ ]	[ ]	1. How would you rate the condition of your mouth? Excellent, Good, Fair or Poor: _____
[ ]	[ ]	2. Previous dentist aside from Dr. Arlene Caringal? _____
[ ]	[ ]	3. I routinely see my dentist every: 3mos, 4mos, 6mos, 9mos, 12mos, not routinely? _____
[ ]	[ ]	4. What is your immediate concern? _____
[ ]	[ ]	5. Are you fearful of dental treatment? _____
[ ]	[ ]	6. Have you had an unfavorable dental experience? _____
[ ]	[ ]	7. Have you ever had complications from past dental treatment? _____
[ ]	[ ]	8. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____
[ ]	[ ]	9. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____
[ ]	[ ]	10. Have you had any teeth removed? _____
[ ]	[ ]	11. Do your gums bleed or are they painful when brushing or flossing? _____
[ ]	[ ]	12. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
[ ]	[ ]	13. Have you ever noticed an unpleasant taste or odor in your mouth? _____
[ ]	[ ]	14. Is there anyone with a history of periodontal disease in your family? _____
[ ]	[ ]	15. Have you ever experienced gum recession? _____
[ ]	[ ]	16. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
[ ]	[ ]	17. Have you experienced a burning sensation in your mouth? _____
[ ]	[ ]	18. Have you had any cavities within the past 3 years? _____
[ ]	[ ]	19. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____

[ ] [ ] 20. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?

_____

[ ] [ ] 21. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?

_____

[ ] [ ] 22. Do you have grooves or notches on your teeth near the gum line?

_____

[ ] [ ] 23. Have you ever broken teeth, chipped teeth, or had toothache or cracked filling?

_____

[ ] [ ] 24. Do you frequently get food caught between any teeth?

_____

[ ] [ ] 25. Do you have any problems with your jaw joint? (pain, sounds, limited opening, locking, popping)?

_____

[ ] [ ] 26. Do you feel like your lower jaw is being pushed back when you bite your teeth together?

_____

[ ] [ ] 27. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?

_____

[ ] [ ] 28. Have your teeth changed in the last 5 years, become shorter, thinner or worn?

_____

[ ] [ ] 29. Are your teeth crowding or developing spaces?

_____

[ ] [ ] 30. Do you have more than one bite and squeeze to make your teeth fit together?

_____

[ ] [ ] 31. Do you chew ice, bite your nails, use your teeth to hold objects, or have any oral habits?

_____

[ ] [ ] 32. Do you clench your teeth in the daytime or make them sore?

_____

[ ] [ ] 33. Do you have any problems with sleep or wake up with an awareness of your teeth?

_____

[ ] [ ] 34. Do you wear or have you worn a bite appliance?

_____

[ ] [ ] 35. Is there anything about the appearance of your teeth that you would like to change?

_____

[ ] [ ] 36. Have you ever whitened (bleached) your teeth?

_____

[ ] [ ] 37. Have you felt uncomfortable or self-conscious about the appearance of your teeth?

_____

[ ] [ ] 38. How often do you brush your teeth?

_____

[ ] [ ] 39. Do you use soft or hard toothbrush?

_____

[ ] [ ] 40. Do you floss? If yes how often?

_____

[ ] [ ] 41. OTHER: if you need to add something that is not in the questions provided:

_____

Patient Signature: _____