

DENTAL HEALTH QUESTIONNAIRE

Name _____ Birthdate _____

Correct answers on the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle the answer which applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

1. Are you having any discomfort at this time? Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? Yes No
If so, explain _____
3. Does dental treatment make you nervous? No Slightly Moderately Extremely
4. Date of last dental visit _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No
If so, when? _____
6. How often do you brush? _____
Toothbrush is: Soft Medium Hard
7. Do you have or have you ever had any of the following?

MOUTH

- Bleeding, sore gums.....Yes No
- Unpleasant taste/bad breath Yes No
- Burning tongue/lips.....Yes No
- Frequent blisters, lips/mouth..... Yes No
- Swelling/lumps in mouth.....Yes No
- Ortho treatments (braces)..... Yes No
- Biting cheeks/lips.....Yes No
- Clicking/popping jaw..... Yes No
- Difficulty opening or closing jaw..... Yes No

TEETH

- Loose Teeth..... Yes No
- Sensitive to hot..... Yes No
- Sensitive to Cold.....Yes No
- Sensitive to Sweets..... Yes No
- Sensitive to biting.....Yes No
- Food Impaction.....Yes No
- Clenching/grinding.....Yes No
- If so, when _____
- Shifting in bite.....Yes No

8. Do you use the following?
 - Brush Yes No
 - Dental floss..... Yes No
 - Fluoride Rinse.....Yes No
 - Other..... Yes No

MEDICAL

1. Has there been any change in your general health within the past year?..... Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician?..... Yes No
4. The name and address of my physician is _____
5. Have you had any serious illness within the past five (5) years?..... Yes No
If so, what was the illness _____
6. Have you been hospitalized or had an operation within the past five (5) years?..... Yes No
7. Do you have any of the following diseases or problems:
 - a. Rheumatic fever or rheumatic heart disease, heart murmur or mitral valve prolapsed..... Yes No
 - b. Congenital heart diseaseYes No
 - c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.)
 - 1) Do you have pain in chest upon exertion?.....Yes No
 - 2) Are you short of breath after mild exercise?Yes No
 - 3) Do your ankles swell?.....Yes No
 - 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep?...Yes No
 - d. Artificial or replacement valves.....Yes No
 - e. Pacemaker Yes No
 - f. Allergy.....Yes No
 - g. Sinus trouble..... Yes No
 - h. Asthma or hay feverYes No
 - i. Hive or a skin rash Yes No
 - j. Fainting spells or seizures.....Yes No
- k. Diabetes
 - 1) Do you have to urinate (pass water) more than six times a day?..... Yes No
 - 2) Are you thirsty much of the time?..... Yes No
 - 3) Does your mouth frequently become dry?..... Yes No
- l. Hepatitis, jaundice or liver disease?.....Yes No
- m. Arthritis or inflammatory rheumatism.....Yes No
- n. Artificial or replacement joints, prosthetic.....Yes No
- o. Digestive system - Ulcers or stomach disorders (colitis)..... Yes No
- q. Tuberculosis Yes No
- r. Persistent cough/cough up blood....Yes No
- s. Other _____

