Dental History Questionnaire

Name of last dental practice: _____
City of last dental practice: _____
Date of last dental visit: _____
Date of last dental x-rays: _____
Reason for today's visit: _____

General:	**(PLEASE CIRCLE)**	
Do you experience bad breath?	YES	NO
History of blisters or ulcers on the lips or inside the mouth?	YES	NO
Experience burning or discoloration of the tongue?	YES	NO
Chew one a single side of the mouth?	YES	NO
Experience dry mouth?	YES	NO
Experience snoring or mouth breathing? (Circle one)	YES	NO
Have you been diagnosed with sleep apnea? If so, do you use a C-pap?	YES	NO
Have you undergone Orthodontic treatment (braces)?	YES	NO
Do you have history of tonsillitis or tonsil removal?	YES	NO
Do you suffer from dental anxiety?	YES	NO
Periodontal:		
Do you experience bleeding gums?	YES	NO
Are you gums noticeably swollen or tender?	YES	NO
Is brushing painful?	YES	NO
Have you noticed any loose teeth?	YES	NO
Do you find food is getting stuck between your teeth?	YES	NO
Have you had a history of periodontal therapy? ("Deep cleanings")	YES	NO
Have you had, or have been recommended to have gum grafts?	YES	NO
Any history of oral piercings?	YES	NO
Dental:		
Do you currently have any known incomplete dental treatment?	YES	NO
Do you have any broken teeth?	YES	NO
Have you experienced grinding or clenching of your teeth?	YES	NO
If so, do you have a night guard?	YES	NO
Do you notice any pain around your ear or jaw joint?	YES	NO
Do you experience clicking or popping of your jaw joint?	YES	NO
Have you ever been diagnosed with Temporomandibular Dysfunction (TMD)?	YES	NO
Do you notice floss catching or shredding between teeth?	YES	NO
Do you have any prosthetics (Complete or partial dentures, "flippers", implants)?	YES	NO
Have you experienced acid reflux?	YES	NO
Do you experience sensitivity to cold?	YES	NO
Do you experience sensitivity to heat?	YES	NO
Do you experience sensitivity to biting, or pressure?	YES	NO
Do you experience sensitivity to sweets?	YES	NO

How often do you brush your teeth? _____

Manual toothbrush: _____ Electric toothbrush: _____

How often do you floss? _____