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DENTAL QUESTIONNAIRE

NAME: DATE:

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| --- | --- | --- | --- | --- |
| **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? |

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| [ | ] | [ | ] | 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: