Dental Questionnaire

Comprehensive Exam

Name:_______________________________ **Date:**_____________

Dental Treatment Questions:

1. Do you feel nervous about having dental treatment?.. ☐ **Yes** ☐ **No**
2. Do you want to discuss sedation options? .... ☐ **Yes** ☐ **No**
3. Have you been treated with Orthodontics in the past?... ☐ **Yes** ☐ **No**
4. Do you want straighter teeth?... ☐ **Yes** ☐ **No**
5. Are you satisfied with the appearance of your teeth?... ☐ **Yes** ☐ **No**
6. If you could have your teeth whitened, would you be interested?............................... ☐ **Yes** ☐ **No**
7. Have you ever had an oral cancer exam?.. ☐ **Yes** ☐ **No**
8. Do you have areas that are difficult to floss?.. ☐ **Yes** ☐ **No**
9. Do you have areas where food catches between your teeth?....................................... ☐ **Yes** ☐ **No**
10. Have you noticed any spots or stains on your teeth that concern you?......................... ☐ **Yes** ☐ **No**
11. Are there old fillings or dental work you would like to change?.................................. ☐ **Yes** ☐ **No**
12. Do you snore?.. ☐ **Yes** ☐ **No**
13. Do you wake up in the morning still feeling tired?... ☐ **Yes** ☐ **No**
14. Do you have tired jaws, especially in the morning?.. ☐ **Yes** ☐ **No**
15. Do you wear removable dentures or partial dentures?... ☐ **Yes** ☐ **No**
16. Are you using any other dental devices (i.e. retainer, bite guard, snoring appliance)?.. ☐ **Yes** ☐ **No**
17. Do you have an unpleasant taste or bad breath?.. ☐ **Yes** ☐ **No**
18. Do you think your dental health affects your overall physical health?.......................... ☐ **Yes** ☐ **No**

Dental Hygiene Questions:

19. Date of last dental cleaning?..

20. How often do you brush?...

21. What do you use to clean your teeth/gums?...

- ☐ **Manual Toothbrush**
- ☐ **Electric Toothbrush**
- ☐ **Floss**
- ☐ **Toothpick**
- ☐ **Waterpick**
- ☐ **Fluoride Rinse**
- ☐ **Tongue Blade**

22. Have you ever been told that you have periodontal disease?..☐ **Yes** ☐ **No**

23. Do your gums bleed when brushing/flossing?...☐ **Yes** ☐ **No**

24. Are you currently using any prescription toothpaste or mouthwash?............................☐ **Yes** ☐ **No**