

# Dental Questionnaire

## Comprehensive Exam

### ***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**