Dental History Questionnaire

Please complete the following questions to allow us to provide the most appropriate care for your needs.

What is the reason for your visit today?_____
_____

Does dental treatment make you nervous or anxious? (please circle one)

No Slightly Moderately Extremely

When was your last dental visit?_____

When was your last dental cleaning?_____

Are you satisfied with the appearance of your teeth? (please circle one) Yes No

What, if anything, would you like to change about your teeth?
_____

Do you ever experience any of the following? (please check all that apply)

___Difficulty opening/ closing jaw
___Clicking or popping of the jaw
___Pain in jaw joint
___Clinching/ grinding
___Unpleasant taste, bad breath
___Bleeding, sore gums
___Frequent blisters, lips/ mouth
___Dry mouth
___Biting cheeks/lips

___Sensitivity to hot
___Sensitivity to cold
___Sensitivity to sweet
___Sensitivity to biting
___Food impaction
___Loose teeth
___Loose dentures
___Uncomfortable dentures
___Trouble with snoring

Name_____ Date_____