Dental Questionnaire

Date of last complete dental exam___________________________________
What is your immediate dental concern?______________________________

☑***Select any of the following options that apply:***
☐Dissatisfied with your teeth and appearance?
☐Are you presently in dental pain?
☐Experienced any unfavorable reaction to dentistry?
☐Have you lost any teeth?
☐Have you ever had orthodontic treatment?
☐Any growth or swellings in your mouth?
☐Do you have any difficulty in swallowing?
☐Do your gums bleed when brushing your teeth?
☐Do you avoid brushing any part of your mouth?
☐Any bad reaction to dental anesthetics?
☐Have you ever been told you have pyorrhea or periodontal disease?
☐Is any part of your mouth sensitive to temperature?
☐Is any part of you mouth sensitive to food?
☐Is any part if your mouth sensitive to drink?
☐Do you have a burning sensation in your mouth?
☐Does food catch between your teeth?
☐Any pain or soreness around your eyes?
☐Any pain or soreness around your ears?
☐Any pain or soreness around you face?
☐Awaken with an awareness of your teeth or jaws?
☐Are you aware of clenching your teeth during the day?
☐Been told you grind your teeth during sleep?
☐Clicking or popping while eating or yawning?
☐Difficulty in opening your mouth widely?
☐Do you have tension headaches?
☐Unpleasant taste or odor in your mouth?
☐Feel you will eventually wear full dentures?
☐Do any members of your family wear dentures?

____ ________________________
Signature **Date**

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