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Dental Questionnaire

Patient Name: _____ Date: _____

Purpose of dental appointment:

Are you having discomfort at this time? ☐ Yes ☐ No

When was your last dental appointment? _____

What was done then?

When was your last dental cleaning? _____

When was your last dental x-ray? _____

Do you take pre-medication antibiotics before dental appointments? ☐ Yes ☐ No

Have you ever experienced: *(please check)*

☐ Extraction complication	☐ Sores or lumps in mouth	☐ Difficulty chewing
☐ Clicking or locking of the jaw	☐ Jaw pain	☐ Headaches or Migraines
☐ Bad Breath	☐ Clenching or grinding of teeth	☐ Braces (orthodontia)
☐ Bleeding gums	☐ Gum (periodontal) treatment	☐ Loose or sore teeth
☐ Sensitive teeth	☐ Problems with Novacaine	☐ Dry Mouth

Do you have removable dentures or partial dentures? ☐ Yes ☐ No
If yes, explain

Do you use: *(please check)*

☐ Water pic ☐ Electric toothbrush ☐ Fluoride rinse ☐ Mouthwash

Are you interested in whiter teeth? ☐ Yes ☐ No

Any other questions or comments about your dental care:

Signature of Patient: *(Type Adult name here)* _____ Date: _____