DENTAL HISTORY QUESTIONAIRE

How would you rate the condition of your mouth? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Date of last dental examination_____ Date last dental cleaning_____

Date of most recent x-rays _____

I routinely see my dentist every: 6 months ☐ 12 months ☐ Not routinely ☐

I routinely see my hygienist every: 3 months ☐ 4 months ☐ 6 months ☐ 12months ☐ Not routinely ☐

How did you hear about us? Friend/relative ☐ D@68 website ☐ Yellow Pages ☐ Yell.com ☐ Magazine advert ☐ Denplan Ref ☐ Google search ☐ Other ☐

How did you obtain our telephone number? Friend/relative ☐ D@68 website ☐ Yellow Pages ☐ Yell.com ☐ Magazine advert ☐ Denplan Ref ☐ Google search ☐ Other ☐

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

	YES	NO
Are you fearful of dental treatment?	☐	☐
Have you had an unfavourable dental experience?	☐	☐
Have you ever had complications from past dental treatment?	☐	☐
Have you ever had trouble getting numb or reactions to local anesthetic?	☐	☐
Did you ever have braces, orthodontics treatment or had your bite adjusted?	☐	☐
Have you had any teeth removed?	☐	☐

SMILE CHARACTERISTICS

Is there anything about the appearance of your teeth that you would like to change?	☐	☐
Have you ever whitened (bleached) your teeth?	☐	☐
Are you self conscious about your teeth?	☐	☐
Have you been disappointed with the appearance of previous dental work?	☐	☐

BITE AND JAW JOINT

Do you/ would you have any problems chewing gum?	☐	☐
Do you/ would you have any problems chewing crusty bread or other hard foods?	☐	☐
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
Are your teeth crowding or developing spaces?	☐	☐
Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	☐	☐
Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
Do you have tension headaches to sore teeth?	☐	☐
Do you wear or have you ever worn a bite appliance?	☐	☐

TOOTH STRUCTURE

Have you had any cavities in the past 3 years?	☐	☐
Do you have a dry mouth?	☐	☐
Are any teeth sensitive to hot, cold biting or sweet?	☐	☐
Have you ever had a tooth ache, cracking filling, broken, chipped or cracked tooth?	☐	☐
Do you avoid brushing any part of your mouth?	☐	☐
Do you feel or notice any holes (i.e. pitting) in your teeth?	☐	☐

GUM AND BONE

Have you ever been diagnosed or treated for periodontal (gum) disease?	☐	☐
Have you ever experienced gum recession?	☐	☐
Is there anyone with a history of periodontal disease in your family?	☐	☐
Do your gums bleed when brushing, flossing or eating?	☐	☐
Are your teeth becoming loose?	☐	☐
Have you ever noticed an unpleasant taste or odour in your mouth?	☐	☐
Have you experienced a burning sensation in your mouth?	☐	☐