West Portal Family Dentistry

Patient Name : ____________________ Birthday:____/____/____

Correct answers to the following will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Check Yes or No, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL HEALTH QUESTIONNAIRE

1. What is the reason for your visit today? ____________________
2. Are you having discomfort at this time? ☐ Yes ☐ No
3. Have you ever had any serious trouble associated with previous dental treatment? ☐ Yes ☐ No

   If Yes, Please Explain: ____________________
4. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
5. Date of last dental visit: ____/____/____

   What was done at that time? ____________________
6. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ☐ Yes ☐ No
7. How often do you bursh? ____________________
8. Your toothbursh is? ☐ Soft ☐ Medium ☐ Hard
9. Do you have or have you ever had any of the following?

MOUTH -

- ☐ Bleeding, Sore Gums
- ☐ Burning tongue/lip
- ☐ Swelling/lumps in your mouth
- ☐ Biting cheeks or lips
- ☐ Difficulty opening or closing jaw
- ☐ Unpleasant taste or Bad breath
- ☐ Frequent blisters, lips/mouth
- ☐ Ortho treatment (braces)
- ☐ Clicking/popping jaw

TEETH -

- ☐ Loose teeth
- ☐ Sensitive to cool
- ☐ Sensitive to biting
- ☐ Shifting in bite
- ☐ Clenching/grinding, If So, When? ____________________
- ☐ Sensitive to hot
- ☐ Sensitive to sweet
- ☐ Food impaction
- ☐ Change in bite

10. Do you use the following?

Toothbrush: ☐ Yes ☐ No Dental Floss: ☐ Yes ☐ No Flouride Rinse: ☐ Yes ☐ No

Other: ______________________________

11. Are you happy with your smile? ☐ Yes ☐ No

12. Would you like the doctor to discuss about cosmetic treatments available to improve your smie? ☐ Yes ☐ No

Additional Comments:

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______________________________ ____/____/____

Patient, Parent or Legal Guardian's Signature ***Date***

______________________________ ____/____/____

Doctor's Signature ***Date***