PATIENT DENTAL QUESTIONNAIRE

What is the main purpose of your visit today?

……

Do you have any concerns or fears about previous dental care?

……

Are you concerned about or experiencing any of the following dental problems? (Please tick as many as it applies)

☐ Sensitivity to hot or cold
☐ Staining of your teeth
☐ Bleeding gums
☐ Food trapping between teeth
☐ Discoloured fillings/teeth
☐ Bad breath
☐ Head/neck aches
☐ Grinding/clenching of your teeth
☐ Clicking/pain in the jaw joints
☐ Roughness of existing fillings
☐ Sensitivity when eating/drinking
☐ Existing crowns/bridges/dentures

Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Have you ever had or require the following for dental treatment?
☐ Gas (Nitrous oxide-laughing gas) ☐ Intravenous Sedation ☐ General Anesthesia

When was the last time you saw a dentist for a checkup? ……

Name of previous dental clinic: …… Dentist: ……

Are you aware of grinding or clenching your teeth? YES / NO

Do you suffer from headaches? YES / NO

Are you happy with your smile? YES / NO
If not, what do you not like about your smile?
☐ Colour ☐ Crowding ☐ Not straight ☐ Missing teeth ☐ Gaps Other: ……

Would you like to discuss enhancing your smile? YES / NO

Have you had any Orthodontic treatment? (Braces, Invisalign) YES / NO

Are you interested in replacing missing teeth? YES / NO

Have you ever seen a Hygienist/Therapist for a clean? YES / NO

Which toothpaste are you currently using? ……

How often do you brush? ☐ Once daily ☐ Twice daily Other: ……

Do you floss? YES / NO
If YES, how often? ……..

Is your toothbrush ☐ Soft ☐ Medium ☐ Hard

Do you use mouth rinse regularly? YES / NO
If YES, what type? ……..

Do you wear removable dentures? YES / NO
If YES, when were they made? ……..

Are you using any other dental device? (Retainer, snoring appliance etc.) YES / NO

Do you snore? YES / NO

Have you had a sleep study? YES / NO

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