Dental Update Questionnaire

Name: _____ **Date:** _____

Please use the reverse side of this sheet to continue comments and answers to any questions you were unable to respond to sufficiently.

1. Are you experiencing any discomfort at this time? Yes ☐ No ☐
   If yes, please explain _____
2. Does dental treatment make you nervous? No ☐ Slightly ☐ Moderately ☐ Very ☐
3. Date of last dental visit _____
4. Have you ever been treated for gum disease? Yes ☐ No ☐
5. Have you ever had gum surgery? Yes ☐ No ☐
6. How often do you brush? _____ Type of brush: Soft ☐ Medium ☐ Hard ☐
7. Do you have, or have you ever had, any of the following?

MOUTH			TEETH		
Bleeding, sore gums	Yes ☐	No ☐	Loose teeth	Yes ☐	No ☐
Unpleasant taste/bad breath	Yes ☐	No ☐	Sensitive to hot	Yes ☐	No ☐
Burning tongue/lips	Yes ☐	No ☐	Sensitive to cold	Yes ☐	No ☐
Frequent blisters – lips/mouth	Yes ☐	No ☐	Sensitive to sweets	Yes ☐	No ☐
Swelling/lumps in mouth	Yes ☐	No ☐	Sensitive to biting	Yes ☐	No ☐
Ortho treatments (braces)	Yes ☐	No ☐	Food impaction	Yes ☐	No ☐
Biting cheeks/lips	Yes ☐	No ☐	Clenching/grinding	Yes ☐	No ☐
Clicking/popping jaw	Yes ☐	No ☐	If so, when...	Day ☐	Night ☐
Difficulty opening/closing	Yes ☐	No ☐	Shifting in bite	Yes ☐	No ☐

8. Do you use fluoride rinse? Yes ☐ No ☐
9. Do you floss? Yes ☐ No ☐
10. Is there anything you would like to change about your smile? _____
11. Would you like whiter teeth? _____
12. Would you like to have fresher breath? _____
13. What things are most important to you about your dental health? _____
14. Have you lost any teeth? Yes ☐ No ☐ If so, have they been replaced? ____ If not, why? _____
15. Are you unhappy with the replacement(s)? Yes ☐ No ☐ If so, why? _____
16. Would you be interested in learning more about permanent replacements? _____
17. Have you ever had Novocain? Yes ☐ No ☐
18. If yes, have you ever-experienced difficulty getting numb? Yes ☐ No ☐ If yes, please explain _____
19. Have you experienced any problems or complications with previous dental treatment? Yes ☐ No ☐
    If yes, please explain _____

20. Please ***circle*** one:
    My mouth is **a)** very comfortable **b)** moderately comfortable **c)** uncomfortable

    1 **a)** think the appearance of my mouth is excellent
      b) am satisfied with the appearance of my mouth
      c) am disappointed with the appearance of my mouth

    2 **a)** will do anything to keep my natural teeth
      b) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them
      c) expect I will eventually lose most/all of my teeth, like my parents did

    3 **a)** have set goals for my oral health with a previous dentist
      b) want to set goals concerning my dental health

    4 **a)** have always done the best that was recommended for my dental health
      b) have not done what dentists have recommended to me
      c) rarely go and don't care much about having any dental work completed

    5 **a)** have put dentistry for myself and family high on my priority list
      b) have put dentistry for myself and my family low on my priority list
      c) have dentistry is on my list, but it's hard to find

    I think my present state of dental health is **a)** excellent **b)** good **c)** poor

20. What are some questions about dentistry that you have never had adequately answered?

_____

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