# DENTAL HISTORY QUESTIONNAIRE

Name: MR. ◯ MRS. ◯ MISS ◯ MS. ◯ MASTER ◯ DR. ◯ _____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1 . What is the reason for your visit today? Are you currently experiencing any dental problems?

2 . Have you been seeing a dentist regularly? If not, why not? YES ◯ NO ◯

3 . Are you nervous during dental visits? YES ◯ N0 ◯ NOT SURE/MAYBE ◯

4 . Have you had a bad experience or complications during dental treatment?

YES ◯ N0 ◯ NOT SURE/MAYBE ◯

5 . When was your last dental visit? What was done at that appointment?

6 . When did you last have dental x-rays?

7 . Have you ever seen a dental specialist? YES ◯ N0 ◯ NOT SURE/MAYBE ◯

8. How often do you brush your teeth? _____ How often do you floss? _____
Do your gums bleed when you brush or floss? YES ◯ N0 ◯

9 . Have you been told to take antibiotics before a dental appointment?

YES ◯ N0 ◯ NOT SURE/MAYBE ◯

10 . Do you feel that you have bad breath? YES ◯ N0 ◯ NOT SURE/MAYBE ◯

11 . Are you happy with the appearance of your teeth? YES ◯ N0 ◯ NOT SURE/MAYBE ◯

12 . Do you have any problems with your jaw (clicking, limited movement, pain)?

YES ◯ N0 ◯ NOT SURE/MAYBE ◯

13 . Have you ever had an injury to the teeth or jaws or been involved in a motor vehicle accident?

YES ◯ N0 ◯ NOT SURE/MAYBE ◯

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____