

## DENTAL HISTORY QUESTIONNAIRE

Rosslyn Family Dental

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of last dental/dental hygiene visit: \_\_\_\_\_

What dental conditions concern you at the present time?: \_\_\_\_\_

What care did you receive at your last dental visit?: \_\_\_\_\_

How often do you receive dental treatment or dental hygiene care?: \_\_\_\_\_

Do you require complete mouth care or emergency treatment? \_\_\_\_\_

What concerns you most about your teeth? \_\_\_\_\_

Are you under the care of a dental specialist? (i.e., orthodontist, endodontist, prosthodontist, periodontist): \_\_\_\_\_

Have you had head and neck radiation therapy? \_\_\_\_\_

Are you presently in any dental pain? \_\_\_\_\_

In order that we may be sensitive to your needs, please tell us of any unpleasant experiences you may have had related to oral care: \_\_\_\_\_

YES NO Have you had radiographs (dental x-rays) within the past year?

### Do you have or have you ever experienced any of the following?

- |     |    |  |
|-----|----|--|
| YES | NO | Bleeding gums (on brushing), sore gums                       |
| YES | NO | Sensitive teeth (hot or cold), where?                        |
| YES | NO | Cold sore  |
| YES | NO | Loose teeth  |
| YES | NO | Dry mouth  |
| YES | NO | Gum recession  |
| YES | NO | Bad breath   |
| YES | NO | Sinus problems   |
| YES | NO | Sore jaw, jaw clicks or pops on opening or closing           |
| YES | NO | Have you experienced any unfavourable reaction to dentistry? |
| YES | NO | Mouth sores  |
| YES | NO | Difficulty chewing   |
| YES | NO | Difficulty swallowing  |
| YES | NO | Toothache  |
| YES | NO | Fractured or broken filling                                  |
| YES | NO | Swelling/abscess   |
| YES | NO | Any accident, injury or surgery to your face, jaw or teeth?  |
| YES | NO | Have your wisdom teeth been removed?                         |
| YES | NO | Are you aware of clenching/grinding your teeth?              |

**Have you experienced any of the following?:**

- |     |    |   |
|-----|----|---|
| YES | NO | Scaling/root planning (cleaning)_____           |
| YES | NO | Tooth extractions_____                          |
| YES | NO | Dental implants _____                           |
| YES | NO | Root canals _____                               |
| YES | NO | Gum surgery _____                               |
| YES | NO | Jaw surgery _____                               |
| YES | NO | Orthodontics/braces _____                       |
| YES | NO | Severe pain in head, neck or jaw _____          |
| YES | NO | Prolonged bleeding after dental treatment _____ |

**Current oral condition:**

- |     |    |  |
|-----|----|--|
| YES | NO | Do you brush your teeth? How often?_____   |
| YES | NO | Do you floss your teeth? How often?_____   |
| YES | NO | What oral aids do you routinely use at home? _____                               |
| YES | NO | Do you want to keep your natural teeth? _____                                    |
| YES | NO | Do you have complete dentures – partial dentures –fixed bridges –implants? _____ |
| YES | NO | Do you clean your dental appliances? _____                                       |
| YES | NO | Are you a mouth breather? _____  |
| YES | NO | Do you favour one side of your mouth? _____                                      |