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? _____