

Health and Dental Screening Questionnaire

We are concerned with your total health and well being. Your responses are strictly confidential. Answering these questions will help us evaluate and assess your condition and determine if additional information is needed in your health and dental assessment. Thank you for your cooperation.

Patient Name: _____ **Date** ___/___/___

Dental History:

1. When was your last dental visit? _____
2. Any sensitive teeth? If yes, describe _____
3. Have you lost any teeth? If yes, where _____
4. Have you had any orthodontic treatment? If yes, when _____
5. Have you had any Oral surgery? If yes, when _____

6. How often do you brush your teeth? _____
7. Do you floss your teeth? If yes, how often? _____
8. Do you use any other dental aids? (Sonicare brush, Water Pik, toothpicks, etc.) _____
9. Have you ever had a less than positive dental experience? If yes, describe _____

10. Any fears or apprehension regarding your dental treatment? If yes, describe _____

11. What are your chief dental concerns or goals for your dental health, teeth, and smile? _____

Periodontal Disease:

1. Yes No Have you ever been informed that you have periodontal (gum) disease?
2. Yes No Do you ever notice bleeding from your gums when you brush or floss?
3. Yes No Do you ever notice a bad taste or unpleasant odor from your mouth?
4. Yes No Do you have loose or sore teeth?
5. Yes No Do you have any areas of receding gums?

Other comments about your gums:

Sleep Apnea Screening:

1. Yes No Have you ever heard of the term "Sleep apnea" or "Sleep Breathing Disorder"?
2. Yes No Have you ever been told that you snore or make unusual sounds while sleeping?
3. Yes No Do you ever feel excessively tired or sleepy?
4. What is your Height?_____Weight?_____ Neck size?_____
5. Yes No Have you experienced any problems with your sleep? If yes, please explain:

Other comments which may be helpful to assess your condition?

Headache and TMJ Screening:

1. Yes No Have you ever experienced headaches, migranes, or discomfort in the head, neck, jaw or facial areas? If yes, how often, and intensity level (rate 1-10, 1 being low and 10 highest):

2. Yes No Have you ever experienced tightness, popping, or clicking from your jaws?
3. Yes No Do you have any symptoms in the neck or shoulder areas?
4. Yes No Do you notice or suspect that you grind or clench your teeth?
5. Yes No Do you have any pressure, pain, or symptoms in your ears?
6. Yes No Any difficulty chewing or eating?

Other comments you would like to make regarding any head, neck, or TMJ symptoms?

Cosmetic Dentistry Screening:

1. Yes No Is there anything about your teeth and smile that you feel is noticeable to others?
2. Yes No Is there anything about the appearance of your teeth and smile that you would like to improve?

Other comments about your appearance?
