cityviewdental
DOWNTOWN FAMILY DENTISTRY

DENTAL QUESTIONNAIRE

Name_____ Date_____
Reason for visit:_____
When was your last dental visit?_____ Your last cleaning? _____

Have you ever had local anesthetic?.....yes no
Have you ever had an unfavorable reaction from local anesthetic?.....yes no
Have you had serious trouble associated with previous dental treatment?.yes no
If so, explain_____
Does dental treatment make you nervous?.....yes no
If yes, check: ___slightly ___moderately ___extremely

How often do you brush your teeth?_____
What texture brush do you use? ___soft ___medium ___hard ___nylon ___natural
Do you use an electric toothbrush?.....yes no
How often do you floss?_____

Do your gums bleed while brushing?.....yes no
Do your gums bleed while flossing?.....yes no
Do you avoid brushing/flossing any part of your mouth?.....yes no

Do you feel twinges of pain when your teeth contact:
hot foods or liquids?.....yes no
cold foods or liquids?.....yes no
sweets (candy, fruits, desserts)?.....yes no
sours (lemons, limes, grapefruit)?.....yes no

Do your gums feel tender or swollen?.....yes no
Do you clench or grind your jaws while sleeping?.....yes no
Do you clench or grind your jaws during the day?.....yes no
Do your jaws ever feel tired?.....yes no