Brothers Dental Health Questionnaire

Patient Name: _____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and how long you have been a patient there: _____

Date of Most Recent Dental Exam: _____ Date of Most Recent Dental X-rays: _____

I routinely see my dentist every: ☐ 3mo. ☐ 4mo. ☐ 6mo. ☐ 12mo. ☐ Not routinely

What is your immediate concern? _____

_____

Are you fearful of dental treatment? How fearful, on a scale of 1 (*least*) to 10 (*most*) _____

Personal History, Check all that apply:

☐ Had an unfavorable dental experience ☐ Had complications from past dental treatment ☐ Had trouble getting numb

☐ Had any reactions to local anesthetic ☐ Had/have braces, orthodontic treatment ☐ Had your bite adjusted

Smile Characteristics, Check all that apply:

☐ Is there anything about the appearance of your teeth that you would like to change?

☐ Have you ever whitened (bleached) your teeth?

☐ Have you ever felt uncomfortable or self-conscious about the appearance of your teeth?

☐ Have you ever been disappointed with the appearance of previous dental work?

Bite and Jaw Joints, Check all that apply:

☐ You have problems with your jaw joint ☐ You have any problems chewing ☐ You wear or have worn a bite appliance

☐ Your teeth have changed in the last 5 years, become shorter, thinner or worn

☐ Your teeth are crowding or developing spaces ☐ You clench your teeth in the daytime or make them sore

☐You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits

☐ You have problems with sleep or wake up with an awareness of your teeth

Tooth Structure, Check all that apply:

☐ Cavities within past 3 years ☐ Food gets caught between any teeth ☐ Any teeth with grooves, notches, chips, a cracked filling or pain

☐ The amount of saliva in your mouth seems too little or you have difficulty swallowing your food

☐ You notice or have holes (i.e. pitting, craters) on the biting surface of your teeth

☐ Any teeth sensitive to hot, cold, biting, sweets, or you avoid brushing any part of your mouth

Gum and Bone, Check all that apply:

☐ Gums bleed when brushing or flossing ☐ Noticed an unpleasant taste or odor in your mouth ☐ History of gum disease in your family

☐ Treated for gum disease or were told you have lost bone around your teeth ☐ Experienced gum recession

☐ Experienced a burning sensation in your mouth ☐ Had any teeth become loose on their own (without injury), or have difficulty eating an apple

If any of the checked boxes need further explanation, please describe: _____