

Name: Date of Birth: Date:

**Dental Questionnaire**

**Please circle “Yes” or “No”.**

|  |  |  |
| --- | --- | --- |
| Are you currently experiencing dental pain or discomfort? | Yes | No |
| Are you currently experiencing sensitivity to hot or cold? | Yes | No |
| Do you wear partials?  Date of placement: | Yes | No |
| Do your gums bleed when you brush or floss? | Yes | No |
| Are your teeth sensitive to cold, hot, sweets or biting? | Yes | No |
| Does food or floss catch between your teeth? | Yes | No |
| Is your mouth excessively dry? | Yes | No |
| Have you had periodontal (gum) surgery? | Yes | No |
| Have you had orthodontic (braces) treatment? | Yes | No |
| Have you had problems associated with previous dental treatment? | Yes | No |
| Are you apprehensive about dental care? | Yes | No |
| Do you have frequent sore throats? | Yes | No |
| Do you experience earaches or neck pain? | Yes | No |
| Do you have any clicking, popping, or discomfort in jaw? | Yes | No |
| Do you have any difficulty chewing or opening and closing? | Yes | No |
| Do you clench or grind your teeth? | Yes | No |
| Do you get sores or ulcers in your mouth? | Yes | No |
| Have you ever had a serious injury to your face, jaw, teeth, or mouth? | Yes | No |

|  |  |  |
| --- | --- | --- |
| Oral habits:   * Thumb/finger habit? * Lip/nail biting habit? * Use of pacifier? | Yes  Yes  Yes | No  No  No |
| Do you currently wear a night guard? | Yes | No |

|  |  |  |
| --- | --- | --- |
| Do you like the shape, color, and length of your teeth? | Yes | No |
| Would you like your teeth whiter? | Yes | No |
| Would you like your teeth straighter, or spaces closed between your teeth? | Yes | No |
| Do you have missing teeth you would like replaced? | Yes | No |
| Do you have any silver fillings that you would want replaced with tooth-colored fillings? | Yes | No |

**Smile Evaluation**

\*\* If you could change anything about your smile, what would you change?

**Sleep Apnea Evaluation**

|  |  |  |
| --- | --- | --- |
| Do you snore loudly? (Loud enough to be heard behind closed doors?) | Yes | No |
| Do you often feel tired, fatigue, or sleepy during the day? | Yes | No |
| Has anyone observed you stop breathing during your sleep? | Yes | No |
| Is your body mass index greater than 28? | Yes | No |