

Health Questionnaire for Dental Evaluation and Treatment

Do you have or have you had any of the following?

- | | | |
|--|---|---|
| <input type="checkbox"/> No diseases or disorders | <input type="checkbox"/> Multiple chemical sensitivities | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Snoring, even a little | <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Daytime sleepiness | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Multiple nighttime awakenings | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Restless leg syndrome | <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Gastric reflux | <input type="checkbox"/> Seizure disorders | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Tooth grinding while sleeping | <input type="checkbox"/> Cancer | <input type="checkbox"/> Organ transplant |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Leukemia | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Vascular disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Fibromalgia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bisphosphonate therapy (Fosamax, Boniva, etc.) | |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Joint replacement | |

Any other disease or disorder What:

Dental History

Your general dentist, with contact information.

How long ago was your last appointment with your dentist or dental hygienist?

Are you currently having dental, periodontal, or orthodontic treatment? Yes No

If yes, list all practitioners, and reasons for treatment.

List any dental specialists you have seen in the past 5 years.

If you have had any bad experiences undergoing dental treatment, please tell us about them.

How do you feel about your smile?

Tell us if there is anything we can do to make your appointment more comfortable. We will be happy to discuss these with you.

- | | |
|---|--|
| <input type="checkbox"/> Nitrous oxide (laughing gas) | <input type="checkbox"/> Anti-anxiety medication |
| <input type="checkbox"/> Special back, leg, or head support | <input type="checkbox"/> Personal music system |
| <input type="checkbox"/> TENS electrical stimulation | <input type="checkbox"/> Calming microelectrical stimulation |
| <input type="checkbox"/> Anything else? What? | |

How often do you brush your teeth?

How often do you floss your teeth?

Do you use any of these other methods of cleaning teeth? Check all that apply.

- | | | | |
|-------------------------------------|--|--|--|
| <input type="checkbox"/> WaterPik | <input type="checkbox"/> Rubber tip stimulator | <input type="checkbox"/> Tongue scraper or brush | <input type="checkbox"/> Floss holders |
| <input type="checkbox"/> Toothpicks | <input type="checkbox"/> Interproximal brushes | <input type="checkbox"/> Anything else - What? | |

Do your teeth or gums ever hurt?

- Yes No Sometimes

Do your gums bleed, for any reason at all, ever?

- Yes No Sometimes

Are your teeth sensitive? Choose all causes that apply.

- Not sensitive Air Heat Cold Sweets Clenching Chewing Brushing Flossing

Do you have any jaw problems? Check all that apply.

- | | | |
|--|--|---|
| <input type="checkbox"/> I have no jaw problems | <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Difficulty opening or closing | <input type="checkbox"/> Difficulty chewing | |
| <input type="checkbox"/> Pain in a jaw joint | <input type="checkbox"/> Clicking in a jaw joint | <input type="checkbox"/> Grinding noises in a jaw joint |
| <input type="checkbox"/> Pain in jaw muscles | <input type="checkbox"/> Pain in face | |

Today's date:

Please type or write your name to confirm your signature: