NEIL R WOODS DDS

DENTAL QUESTIONNAIRE

NAME_____ DATE_____

1. Reason for visit_____
2. How long since your last visit to the Dentist?_____
3. What was done for you at that time?_____
4. Have you ever had any problem with previous dental treatment?_____
5. How often you visit a dentist?_____
6. How often do you brush your teeth?_____
7. What texture tooth brush do you use: (circle one)
   soft *medium* *hard*
8. How often do you floss? (circle one)
   never *rarely* *once a week* *once a day* *more*
9. Do your gums bleed? (circle one)
   never *rarely* *frequently* *while brushing* *while flossing*
10. Do you avoid brushing any part of your mouth?_____ YES NO
11. Do you chew on one side of your mouth?_____ YES NO
12. Do your gums feel tender or swollen?_____ YES NO
13. Did you know that after the age of 35 more teeth are lost from periodontal (gum) disease than from decay?_____ YES NO
14. Do you know that tartar usually forms under gums if your gums bleed?_____ YES NO
15. Do you know extensive destruction of bone under the gum can take place without the patient being aware of it?_____ YES NO
16. How often do you have your teeth professionally cleaned?_____
17. Do you feel twinges of pain when your teeth come in contact with:
    (a) hot foods or liquids, i.e. soup, coffee, tea, etc.?_____ YES NO
    (b) cold foods or liquids, i.e. ice cream, cold fruit?_____ YES NO
    (c) sweets, i.e. candy, sweet desserts, etc.?_____ YES NO
    (d) sours, i.e. lemons, grapefruits, etc.?_____ YES NO
18. Do you clench or grind your teeth (jaws) while sleeping or during the day?_____ YES NO
19. Do your jaws ever feel tired?_____ YES NO
20. Do you wear dentures (partial or full)?_____ YES NO
21. Do you usually have many cavities?_____ YES NO
22. Do you lose fillings or break fillings?_____ YES NO
23. Do you gag easily?_____ YES NO
24. Are you familiar with the term "preventive dentistry"?_____ YES NO
25. Does food catch between our teeth?_____ YES NO
26. Have you ever had professional instruction in home care?_____ YES NO
27. Are you satisfied with the appearance of your teeth?_____ YES NO
    If not, why?_____
28. Have you had a complete examination of your mouth?_____ YES NO
    Did it include (circle ones that apply):
    x-rays:: full mouth *Panoramic* *a few* *other*
    gums *muscles, head, neck & mouth* *models of your teeth* *teeth* *oral cavity & neck for tumors*
    When (circle one): 6 months ago or less 1 year ago 2 or more years ago
29. Do you wish (circle one):
    complete mouth treatment *emergency care*

COMMENTS:_____

_____

_____

_____

Patient's Signature