

PIEDMONT FAMILY DENTISTRY DENTAL HISTORY QUESTIONNAIRE

Please complete this form in its entirety. Check if you have, or have had, any of the following:

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:
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PLEASE ANSWER THE QUESTIONS BELOW.

Visit History	How often do you visit the Dentist?	
	<input type="checkbox"/> Unknown <input type="checkbox"/> Never/First visit <input type="checkbox"/> 1-2 per year <input type="checkbox"/> More than twice a year <input type="checkbox"/> Irregular <input type="checkbox"/> Emergencies	
	Are you having any discomfort at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you need treatment every time you visit the Dentist? <input type="checkbox"/> Yes! <input type="checkbox"/> Sometimes, but not always <input type="checkbox"/> Nope, my teeth are great!	
	When is the last time you had a dental cleaning? <input type="checkbox"/> 6 months ago <input type="checkbox"/> 1-2 years ago <input type="checkbox"/> Over 2 years ago <input type="checkbox"/> Never	
Sensitivity	Are your teeth sensitive to:	
	Sweets?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Hot?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Mouth	Does your mouth feel dry? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you feel thirsty all the time? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Gums	Do your gums bleed when you brush? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do they bleed when you floss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do your teeth wiggle- even slightly? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you ever had gum surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you ever had, or have you ever been recommended a "deep cleaning"? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Grinding/Jaws	Do you have pain in your jaw joints (TMJ)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Does your jaw joint pop or click? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have difficulty chewing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you clench your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you grind your teeth? If yes, do you wear a nightguard? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diet	Do you tend to sip on soft drinks for periods of time? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you tend to suck on hard candy or cough drops throughout the day? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	How many soft drinks (diet or regular), or sweet drinks (sweet tea, juice, sports drinks) do you drink in a day? <input type="checkbox"/> 5 or more <input type="checkbox"/> 4 or less	
Habits	Smoking and Tobacco Habits	
	<u>Cigarette History</u> <input type="checkbox"/> Never Used <input type="checkbox"/> Former Smoker- <input type="checkbox"/> Less than 10 per day <input type="checkbox"/> More than 10 per day Age began smoking cigarettes _____ Year Quit _____	<u>Cigar/Pipe Use</u> <input type="checkbox"/> Never used <input type="checkbox"/> Former smoker <input type="checkbox"/> Less than 1 per day <input type="checkbox"/> 1-2 per day <input type="checkbox"/> More than 2 per day Age began smoking cigar/pipe _____ Year Quit _____
	<u>Smokeless Tobacco Use</u> <input type="checkbox"/> Never used <input type="checkbox"/> Former user <input type="checkbox"/> Occasional user <input type="checkbox"/> Daily use Age began using tobacco _____ Year Quit _____	

	Alcohol Consumption		
	<input type="checkbox"/> Never had more than 12 drinks in any year of my life <input type="checkbox"/> I've had more than 12 drinks in one year, but not in the past year. <input type="checkbox"/> I've had more than 12 drinks in the past year, and less than 3 drinks a week <input type="checkbox"/> I've had 3 to 14 drinks per week on average in the past year <input type="checkbox"/> I have 2-3 drinks per day for the past year <input type="checkbox"/> I have more than 3 drinks per day in the past year.		
Other	Do you have a pierced tongue or oral habit (eating ice, playing musical instrument with mouthpiece, opening bottles) that places excessive stress on your teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Cosmetics	Are you satisfied with the color of your teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you satisfied with the alignment of your teeth (how straight they are?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you satisfied with the spacing of your teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you interested in whitening treatments?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sores	Do you have or have you ever had any swelling in your mouth or gums?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you suffer with fever blisters? If so, how long do they last? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you suffer from ulcers? If so, how long do they last? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does your tongue itch or burn?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you bite your cheek?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ORAL HYGEINE

How many times a day do you brush your teeth _____	How many times a day do you floss?		
How often do you change your toothbrush? _____			
What is the texture of your toothbrush (select one)? <input type="checkbox"/> Soft <input type="checkbox"/> Medium <input type="checkbox"/> Hard			
What type of toothbrush do you use (select one)? <input type="checkbox"/> Manual <input type="checkbox"/> Electric			
Do you brush your tongue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you chew gum? If yes, write the brand that you chew most often? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you use mouthwash? If yes, which brand? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Who supplies your household drinking water (select one)? <input type="checkbox"/> Municipality (city, county) <input type="checkbox"/> We use well-water			
If you use well-water, do you add fluoride?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
What brand of toothpaste do you use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you suffer from persistent bad breath (halitosis)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

OTHER QUESTIONS

<input type="checkbox"/> Radiation therapy to the head or neck	Are you a Diabetic? <input type="checkbox"/> Unknown <input type="checkbox"/> Not Diabetic <input type="checkbox"/> Good diabetic control <input type="checkbox"/> Fair Diabetic Control <input type="checkbox"/> Poor Diabetic Control	Cancer History	
<input type="checkbox"/> Blood Thinners		Have you ever had:	Has your parent or sibling ever had?
<input type="checkbox"/> GERD (acid reflux)		<input type="checkbox"/> Breast	<input type="checkbox"/> Breast
<input type="checkbox"/> Injury or trauma to the mouth, face or jaws		<input type="checkbox"/> Colon or rectum	<input type="checkbox"/> Colon or rectum
<input type="checkbox"/> Boniva or treatment for osteoporosis?		<input type="checkbox"/> Lung and Bronchus	<input type="checkbox"/> Lung and Bronchus
<input type="checkbox"/> Do you take vitamins?		<input type="checkbox"/> Oral cavity	<input type="checkbox"/> Oral cavity
<input type="checkbox"/> Have you had a major change in health (heart attack, stroke, etc) during the past 12 months?	<input type="checkbox"/> Prostate	<input type="checkbox"/> Prostate	
	<input type="checkbox"/> Skin	<input type="checkbox"/> Skin	
	<input type="checkbox"/> Urinary bladder	<input type="checkbox"/> Urinary bladder	
	<input type="checkbox"/> Uterine	<input type="checkbox"/> Uterine	
	<input type="checkbox"/> Other	<input type="checkbox"/> Other	
	<input type="checkbox"/> None	<input type="checkbox"/> None	