Dental History Questionnaire Name: ________________________ Date: ______________

When was your last dental visit?___________ Hygiene Visit?____________ X-Rays?_____________

What are your goals for your dental health and what would you like to accomplish together?
____

Tell us about your previous dental experiences. Have they been favorable and comfortable or a poor experience? (Explain any poor experience) ____

Rate your smile: What do you think of your smile on a scale of 1-10 (10 being movie star), how would your rate your smile? ____

Are you happy with the appearance of your teeth/gums/smile? Y/N
Would you like to discuss enhancing the appearance of your smile? Y/N
If so, what don't you like about your smile? ____

Do you have a chronically Dry Mouth?: Y / N

Nutritional Habits and Diet:
What type of diet do you eat? Vegetarian, Low Fat, Weight Loss, Low sodium, High Starchy Carb rich foods, Non-specific diet: ____

Are snacks or beverages containing sugar consumed between meals 4 or more times per day? Y/N

Drink Consumption:
Do you drink Carbonated beverages (soda-diet or regular), flavored water, fruit juice, sports/energy drinks, red or white wine? ____

Do you sip your drink throughout the day or do you finish your drink all at once? _______________

Do you bite your fingernails, objects (pens, etc), or clench/grind your teeth? ____________________

Self Care:
What do you do at home to take care of your teeth?
____

What, if any, difficulty do you have with self-care due to physical limitations? _________________

Medical Risk Factors:
How has your health been this year? ____

What significant changes have there been to your health or medications?
____

Family Medical History:
Have you or any of your family members had or have any of the following medical conditions? Y/N

Condition	You	Mother	Father	Sibling	Other
Hypertension					
Heart Disease					
Diabetes					
Cancer					
Thyroid condition					
Gum Disease					
Tooth Loss					