Peak Family Dentistry

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DENTAL HISTORY QUESTIONNAIRE

DENTAL HISTORY

NAME _____ ***Referred By*** _____

Please state briefly the reason for your visit _____

_____

How long since your last dental visit? _____

Do you now, or have you ever worn a CPAP? _____

Were X-rays taken of all teeth at that time? ..... YES _____ NO _____

Do you have discomfort in your mouth now? ..... YES _____ NO _____

Do your gums bleed, feel tender or irritated? ..... YES _____ NO _____

Are your teeth sensitive to hot / cold / sweets? ..... YES _____ NO _____

Does food wedge between certain teeth? ..... YES _____ NO _____

Are any teeth loose? ..... YES _____ NO _____

Do you grind, clench or grit your teeth? ..... YES _____ NO _____

Does your jaw ever click or cause pain on opening or closing? ..... YES _____ NO _____

Have your front teeth separated creating spaces recently? ..... YES _____ NO _____

Have you ever had any teeth extracted? ..... YES _____ NO _____

If yes, have they been replaced to prevent shifting of tipping? ..... YES _____ NO _____

Did you ever wear braces? ..... YES _____ NO _____

Have you ever worn a dental appliances? *(i.e. night guard, retainer, etc)* ..... YES _____ NO _____

Have you ever had a root canal? ..... YES _____ NO _____

Have you ever had gum treatments? ..... YES _____ NO _____

Do you wear dentures or partials? ..... YES _____ NO _____

If yes, are you satisfied with the fit? ..... YES _____ NO _____

Have you ever experienced any growths or sore spots in your mouth? ..... YES _____ NO _____

Do you have an unpleasant taste in your mouth? ..... YES _____ NO _____

Do you floss your teeth? ..... YES _____ NO _____

Do you use tobacco products? ..... YES _____ NO _____

What type of toothbrush do you use? _____

_____ _____

Signature of Patient or Responsible Party *Date*