

# Dental History Questionnaire

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Please list your name above: Last First Middle

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? Yes No
2. Date of last dental visit?
3. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth?) Yes No

### Do you have or ever had the following:

Bleeding, sore gums? Yes No

Unpleasant taste/bad breath? Yes No

Burning tongue/lips? Yes No

Frequent blister, lips/mouth? Yes No

Swelling/lumps in mouth? Yes No

Orthodontic treatment (braces?) Yes No

Biting cheeks/lips? Yes No

Clicking/popping jaw? Yes No

Difficulty opening or closing jaw? Yes No

Loose teeth? Yes No

Shifting in bite? Yes No

Change in bite? Yes No

Food impaction? Yes No

Sensitive teeth (hot, cold, sweets or biting?) Yes No - If yes please list \_\_\_\_\_.

Clenching/grinding? Yes No When \_\_\_\_\_.

### Do you use the following:

Tooth Brush? Yes No - If yes, what type - Soft Medium Hard

Dental Floss? Yes No - If other please list \_\_\_\_\_

Proxabrush? Yes No

Does dental treatment make you nervous? - No Slightly Moderately Extremely

### Circle one:

1. Please evaluate the importance of your teeth:

(Dont Care) 1 2 3 4 5 6 7 8 9 10 (Extremely Important)

2. What level do you think your current oral health is in?

(poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

3. Is there anything about your teeth you would like to change? If so please list. \_\_\_\_\_

4. What condition would you like your oral health to be in ten years from now? \_\_\_\_\_

5. Please rank the following options in the order in which they would prevent you from having dental treatment. (1-4, 1 being highest) Fear of pain \_\_\_ Cost of treatment \_\_\_

Lack of concern \_\_\_ Missing days from work \_\_\_

6. Have you had any positive dental experiences. Yes No - If yes please list. \_\_\_\_\_

7. Any negative experiences? Yes No - If yes please list. \_\_\_\_\_

8. Is there anything you would like to know about our office? \_\_\_\_\_