

Dental Health Questionnaire

Do your gums bleed or hurt? Y N
Do you feel your breath is offensive? Y N
Do you get food caught in your teeth? Y N
Are you happy with appearance of your teeth? Y N
Do you brush regularly? Y N

Do you have an unpleasant taste in your mouth? Y N
Do you have discolored teeth? Y N
Are your teeth sensitive? Y N
Are you missing teeth? Y N
Do you floss regularly? Y N

Do you get headaches or migraines? Y N Where? _____
Do you get neck aches or stiff necks? Y N
Do you have trouble sleeping soundly? Y N
Do you wake up with sore teeth? Y N
Do you clench or grind your teeth? Y N When? Day Night Both

Have you ever had a severe blow to the head or jaw? Y N
Have you ever had whiplash? Y N

Does your jaw feel tired after a big meal? Y N
Do you ever get dizzy? Y N
Do you ever have popping or clicking in your jaw? Y N
Has your jaw ever locked? Y N
Do you have difficulty opening wide or yawning? Y N

Are there any foods you avoid eating? Y N
Do you ever feel faint? Y N
Do you ever get nauseated? Y N
Do you have TMJ problems? Y N
Do you have regular pain in your jaw? Y N

Do you have pain in either ear? Y N
Do you have stuffiness in your ear? Y N
Do you wear glasses or contacts? Y N

Do you suffer from hearing loss? Y N
Do you have ringing in your ear? Y N
Do your eyes get blurry? Y N

Do you have allergies? Y N
Do you snore? Y N
Have you ever been diagnosed with Sleep Apnea? Y N

Do you have sinus problems? Y N
Is your nose always stuffy? Y N
Have you ever had a Sleep Study Done? Y N

What are your expectations of our office? _____

What is your main focus of your teeth? _____

Do you want to save your teeth? _____

How was your last dental visit? _____

What do you think about dentistry in general? _____

What would you change about your smile? _____

Is there anything additional you would like to share with us? _____

Please circle services interested in and would like information on

Invisalign ~ Veneers ~ Zoom Whitening ~ Perio Protect ~ Implants ~ Sleep Apnea ~ Vizilite Plus