

DENTAL HISTORY QUESTIONNAIRE

NAME: _____ DATE: _____

1. Have you ever had treatment for gum disease? Yes No
 If yes, what kind and when? _____
2. Have you ever had treatment for halitosis? Yes No
 If yes, what kind and when? _____
3. Do you think you have a breath problem? Yes No
 If yes, describe it. _____
4. Does anyone in your family suffer from periodontal disease or breath odour? Yes No
 If yes, who? _____
5. Do you ever have an unpleasant taste in your mouth in the morning? Yes No
 If yes, describe it. _____
6. Do you have an unpleasant taste in your mouth when you clean between your teeth? Yes No
 If yes, describe it. _____
7. Do your gums bleed when you clean between your teeth? Yes No
8. Does your mouth feel dry? Yes No
9. Do you have factors in your life that cause a great deal of stress? Yes No
 If yes, what are they? _____

HABITS

1. Do you smoke? Yes No How much? _____
2. Do you drink alcohol? Yes No How much? _____
3. Do you use commercial mouthwashes? Yes No Which ones? _____
4. Do you use gums, candies or mints? Yes No Occasionally
5. Do you scrape your tongue? Yes No Occasionally
6. Do you floss daily? Yes No Occasionally
7. Do you use interdental cleaners daily? Yes No Occasionally

Thank you for answering this questionnaire.
 Your answers will help us to prepare a treatment plan for your dental needs.