NORTH TEXAS
PERIODONTAL SPECIALISTS

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PERIODONTICS & DENTAL IMPLANTS

DENTAL QUESTIONNAIRE

PATIENTS NAME _____

GENERAL DENTIST'S NAME_____FOR HOW LONG_____

HOW FREQUENTLY HAVE YOU HAD YOUR TEETH CLEANED DURING THE PAST 5 YEARS:

❑LESS THAN ONCE A YEAR ❑ONCE A YEAR ❑TWICE A YEAR ❑THREE TIMES A YEAR ❑FOUR TIMES A YEAR

MO/YEAR OF YOUR LAST DENTAL EXAM_____ YEAR OF YOUR LAST DENTAL X-RAYS _____

ARE YOU PRESENTLY SATISFIED WITH THE CONDITION OF YOUR MOUTH AND TEETH (CIRCLE ONE): YES NO

YES	NO	
❑	❑	DO YOU PRESENTLY HAVE ANY PAIN, DISCOMFORT OR IMPAIRED FUNCTION RELATED TO YOUR MOUTH? IF YES, PLEASE DESCRIBE? _____
❑	❑	ARE YOU CURRENTLY AWARE OF ANY INFECTION IN YOUR MOUTH IF YES, PLEASE DESCRIBE: _____
❑	❑	ARE YOU CURRENTLY TAKING ANY ANTIBIOTICS FOR INFECTION? IF SO, WHAT: _____
❑	❑	DO YOUR GUMS EVER BLEED? IF SO, WHEN: _____
❑	❑	DO YOU HAVE A PROBLEM WITH BAD BREATH OR HAVE ANY FRIENDS OR FAMILY MADE YOU AWARE OF THIS?
❑	❑	ARE YOU INTERESTED IN REPLACING LOST TEETH?
❑	❑	DO YOU EVER HAVE ACHES OR PAINS IN YOUR JAW JOINTS, EARS, FACE, NECK OR HEAD?
❑	❑	ARE ANY OF YOUR TEETH TENDER WHEN YOU CHEW HARD FOODS?
❑	❑	ARE ANY OF YOUR TEETH MORE SENSITIVE TO: COLD, HOT, SWEETS, CERTAIN FOODS OR DRINKS?
❑	❑	ARE ANY PARTICULAR TEETH VERY SENSITIVE OR PAINFUL? WHEN? _____
❑	❑	ARE YOU CONCERNED ABOUT GUM RECESSION AROUND ANY OF YOUR TEETH?
❑	❑	ARE YOU CONCERNED ABOUT THE APPEARANCE OF YOUR TEETH OR MOUTH?
❑	❑	HAVE YOU EVER HAD ORTHODONTIC TREATMENT? ❑ WITH BRACES ❑ WITH REMOVABLE APPLIANCES WHEN DID YOU GO THROUGH ORTHODONTIC CARE? _____
❑	❑	HAVE YOU EVER RECEIVED PERIODONTAL TREATMENT? ❑SCALING/ROOT PLANING ❑GUM SURGERY WHEN DID YOU GO THROUGH PERIODONTAL CARE? _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____DATE_____

REVIEWED BY: _____DATE_____