Dental Questionnaire

Correct answers to the following questions will allow Dr. Vetter 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. Have you ever had any serious trouble associated with previous dentistry? ___YES ___ NO
3. Does dental treatment make you nervous? ___NO ___Slightly ___Moderately ___Extremely
4. Name of last Dentist ______________________ Date of last dental visit? ____________________
5. Have you ever been treated for periodontal/gum disease? ___YES ___ NO
6. How often do you brush?______________________ The brush is:  ___ Soft ___ Medium ___ Hard
7. Do you have or have you ever had any of the following:
   MOUTH
   Bleeding, sore gums ___YES ___ NO
   Unpleasant taste/ bad breath ___YES ___ NO
   Burning tongue/lips ___YES ___ NO
   Frequent blisters, lips/mouth ___YES ___ NO
   Swelling/lumps in mouth ___YES ___ NO
   Ortho treatments (braces) ___YES ___ NO
   Biting cheeks/lips ___YES ___ NO
   Clicking/popping jaw ___YES ___ NO
   Difficulty opening or closing jaw ___YES ___ NO
   TEETH
   Loose teeth ___YES ___ NO
   Sensitive to hot ___YES ___ NO
   Sensitive to cold ___YES ___ NO
   Sensitive to sweets ___YES ___ NO
   Sensitive to biting ___YES ___ NO
   Food impaction ___YES ___ NO
   Clenching/grinding ___YES ___ NO
   If so, when__________________________
   Shifting in bite ___YES ___ NO
8. Do you use the following?
   Electric toothbrush ___YES ___ NO
   Floss ___YES ___ NO
   Fluoride rinse ___YES ___ NO
   Other ______________________________
   These are things that are important to me about my dental health:

   __________________________________________________________________________
   __________________________________________________________________________
   What do you fear most about dental care?

   __________________________________________________________________________
   __________________________________________________________________________

Circle One:
1. My mouth is
   A.) very comfortable.
   B.) moderately comfortable.
   C.) uncomfortable.

2. I (am)
   A.) think the appearance of my mouth is excellent.
   B.) satisfied with the appearance of my mouth.
   C.) dissatisfied with the appearance of my mouth.

3. I
   A.) will do anything to keep my natural teeth.
   B.) want to keep my teeth, but have a certain budget of time and money I am willing to spend on them.
   C.) don’t care whether I keep my teeth or not.

4. I
   A.) have set goals for my oral health with a previous dentist.
   B.) want to set goals concerning my dental health.
   C.) never set goals concerning my dental health.

5. I
   A.) have always done the best that was recommended for my dental health.
   B.) have not done what dentists have recommended for my mouth.
   C.) rarely go, and don’t care much about having my dental work completed.

6. I have
   A.) put dentistry for myself and my family high on my priority list.
   B.) put dentistry for myself and my family low on my priority list.
   C.) it’s on my list but hard to find.

7. I think my present state of dental health is
   A.) Excellent
   B.) Good
   C.) Poor

8. I aspire to a mouth with
   A.) excellent health
   B.) good health
   C.) poor health

9. What is/are your primary concerns?
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________