# Dental History Questionnaire

1. What brings you to our office today?
________________________________________________________________________________
________________________________________________________________________________

2. Are you having any discomfort at this time?
________________________________________________________________________________
________________________________________________________________________________

3. Do you have any missing teeth? Yes_____ No_____

4. Would you like to discuss implants today?
________________________________________________________________________________
________________________________________________________________________________

5. Does your jaw pop, click or hurt? Yes _____ No______

6. Are your teeth sensitive? Yes_____ No _____ Hot? ____ Cold? ____ Air? ____ Other_____

7. Do your Gums bleed? Yes ____ No ____

8. Do you clench or Grind your teeth? Yes _____ No _____

9. Have you ever had gum treatment/ deep cleanings? Yes _____ No _____

If yes please explain:
________________________________________________________________________________
________________________________________________________________________________

10. Have you ever had braces or Invisalign? Yes ______ No _______

11. Are you interested in Invisalign? Yes ______ No ______

12. Do you feel you may have bad breath? Yes ______ No ______

13. Have you ever had an unpleasant dental experience? Yes _____ No _______ If so please explain:
________________________________________________________________________________
________________________________________________________________________________

14. What do you feel the overall condition of your mouth is? (1- good, 10- I need a lot of work)
please circle one: 1 2 3 4 5 6 7 8 9 10

| ____________________________________ | ___________________ | _______________ |
|---|---|---|
| Patient's/Guardian Signature | Date | Doctor's Initials |


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