NRV Family and Sports Dentistry
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DENTAL HISTORY QUESTIONNAIRE

Please complete this form in its entirety. Check if you have, or have had, any of the following:

Name *(Last, First, M.I.)*:	☐ M ☐ F	**DOB:**

PLEASE ANSWER THE QUESTIONS BELOW.			
Visit History	**How often do you visit the Dentist?** ☐ Unknown ☐ Never/First visit ☐ 1-2 per year ☐ More than twice a year ☐ Irregular ☐ Emergencies		
	Are you having any discomfort at this time? ☐ Yes ☐ No		
	Do you need treatment every time you visit the Dentist? ☐ Yes! ☐ Sometimes, but not always ☐ Nope, my teeth are great!		
	When is the last time you had a dental cleaning? ☐ 6 months ago ☐ 1-2 years ago ☐ Over 2 years ago ☐ Never		
Sensitivity	Are your teeth sensitive to:		
	Sweets?	☐ Yes	☐ No
	Hot?	☐ Yes	☐ No
	Cold?	☐ Yes	☐ No
	Pressure?	☐ Yes	☐ No
Dry Mouth	**Does your mouth feel dry?**	☐ Yes	☐ No
	Do you feel thirsty all the time?	☐ Yes	☐ No
Gums	Do your gums bleed when you brush?	☐ Yes	☐ No
	Do they bleed when you floss?	☐ Yes	☐ No
	Do your teeth wiggle- even slightly?	☐ Yes	☐ No
	Have you ever had gum surgery?	☐ Yes	☐ No
	Have you ever had, or have you ever been recommended a "deep cleaning"?	☐ Yes	☐ No
Grinding/Jaws	Do you have pain in your jaw joints (TMJ)?	☐ Yes	☐ No
	Does your jaw joint pop or click?	☐ Yes	☐ No
	Do you have difficulty chewing?	☐ Yes	☐ No
	Do you clench your teeth?	☐ Yes	☐ No
	Do you grind your teeth? If yes, do you wear a nightguard?___________________	☐ Yes	☐ No
Diet	Do you tend to sip on soft drinks for periods of time?	☐ Yes	☐ No
	Do you tend to suck on hard candy or cough drops throughout the day?	☐ Yes	☐ No
	How many soft drinks (diet or regular), or sweet drinks (sweet tea, juice, sports drinks) do you drink in a day? ☐ 5 or more ☐ 4 or less		
Habits	**Smoking and Tobacco Habits**		

Cigarette History	**Cigar/Pipe Use**	**Smokeless Tobacco Use**
☐ Never Used ☐ Former Smoker- ☐ Less than 10 per day ☐ More than 10 per day Age began smoking cigarettes_____ Year Quit__________	☐ Never used ☐ Former smoker ☐ Less than 1 per day ☐ 1-2 per day ☐ More than 2 per day Age began smoking cigar/pipe_____ Year Quit__________	☐ Never used ☐ Former user ☐ Occasional user ☐ Daily use Age began using tobacco_____ Year Quit__________

	Alcohol Consumption ☐ Never had more than 12 drinks in any year of my life ☐ I've had more than 12 drinks in one year, but not in the past year. ☐ I've had more than 12 drinks in the past year, and less than 3 drinks a week ☐ I've had 3 to 14 drinks per week on average in the past year ☐ I have 2-3 drinks per day for the past year ☐ I have more than 3 drinks per day in the past year.		
Other	**Do you have a pierced tongue or oral habit (eating ice, playing musical instrument with mouthpiece, opening bottles) that places excessive stress on your teeth?**	☐ Yes	☐ No

Cosmetics	Are you satisfied with the color of your teeth?	☐ Yes	☐ No
	Are you satisfied with the alignment of your teeth (how straight they are?)	☐ Yes	☐ No
	Are you satisfied with the spacing of your teeth?	☐ Yes	☐ No
	Are you interested in whitening treatments?	☐ Yes	☐ No
Sores	Do you have or have you ever had any swelling in your mouth or gums?	☐ Yes	☐ No
	Do you suffer with fever blisters? If so, how long do they last? ___________________	☐ Yes	☐ No
	Do you suffer from ulcers? If so, how long do they last? ______________________	☐ Yes	☐ No
	Does your tongue itch or burn?	☐ Yes	☐ No
	Do you bite your cheek?	☐ Yes	☐ No

ORAL HYGEINE

How many times a day do you brush your teeth_________________ How many times a day do you floss? ____________________		
How often do you change your toothbrush? ___________________		
What is the texture of your toothbrush (select one)? ☐Soft ☐Medium ☐ Hard		
What type of toothbrush do you use (select one)? ☐ Manual ☐Electric		
Do you brush your tongue?	☐ Yes	☐ No
Do you chew gum? If yes, write the brand that you chew most often?___________________________________	☐ Yes	☐ No
Do you use mouthwash? If yes, which brand?____	☐ Yes	☐ No
Who supplies your household drinking water (select one)? ☐Municipality (city, county) ☐ We use well-water		
If you use well-water, do you add fluoride?	☐ Yes	☐ No
What brand of toothpaste do you use?	☐ Yes	☐ No
Do you suffer from persistent bad breath (halitosis)?	☐ Yes	☐ No

OTHER QUESTIONS

☐	Radiation therapy to the head or neck
☐	Blood Thinners
☐	GERD (acid reflux)
☐	Injury or trauma to the mouth, face or jaws
☐	Boniva or treatment for osteoporosis?
☐	Do you take vitamins?
☐	Have you had a major change in heath (heart attack, stroke, etc) during the past 12 months?

Are you a Diabetic?

☐ Unknown
☐ Not Diabetic
☐ Good diabetic control
☐ Fair Diabetic Control
☐ Poor Diabetic Control

Cancer History

Have you ever had:	**Has your parent or sibling ever had?**
☐ Breast	☐ Breast
☐ Colon or rectum	☐ Colon or rectum
☐ Lung and Bronchus	☐ Lung and Bronchus
☐ Oral cavity	☐ Oral cavity
☐ Prostate	☐ Prostate
☐ Skin	☐ Skin
☐ Urinary bladder	☐ Urinary bladder
☐ Uterine	☐ Uterine
☐ Other	☐ Other
☐ None	☐ None