

Sample Medical and Dental History Questionnaire (Part 2)

DENTAL HISTORY QUESTIONNAIRE

- > When was your last dental visit? _____
- > When did you last have dental x-rays? _____
- > How often do you brush your teeth? _____
- > How often do you floss your teeth? _____

	YES	NOT SURE/ MAYBE	NO
> Have you been seeing a dentist regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Do any of your teeth ache?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Have you ever been advised to take antibiotics before dental appointments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Do you have any pain when you chew?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Do you feel that you have bad breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Have you ever been in a vehicle accident or experienced any blows to your jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Have you ever had any implant surgery in one or both of your jaws or jaw joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> If you answered "yes," to the last question, who performed the surgery and when was it done? _____			
> Are you being followed up by a dental specialist? _____			
> Please list anything else not mentioned above regarding your past dental history. _____			
