Sample Dental History Questionnaire

Dental History Questionnaire

Name: MR./MISS/MRS./MS./DR.

The following information is required to enable us to provide you with the best possible dental care.
All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. What is the reason for your visit today? Are you currently experiencing any dental problems?

2. Have you been seeing a dentist regularly? If not, why not? ☐ Yes ☐ No

3. Are you nervous during dental visits? ☐ Yes ☐ No ☐ Not Sure/Maybe

4. Have you had a bad experience or complications during dental treatment? ☐ Yes ☐ No ☐ Not Sure/Maybe

5. When was your last dental visit? What was done at that appointment?

6. When did you last have dental x-rays?

7. Have you ever seen a dental specialist? ☐ Yes ☐ No ☐ Not Sure/Maybe

8. How often do you brush your teeth? How often do you floss? Do your gums bleed when you brush or floss?

9. Have you been told to take antibiotics before a dental appointment? ☐ Yes ☐ No ☐ Not Sure/Maybe

10. Do you feel that you have bad breath? ☐ Yes ☐ No ☐ Not Sure/Maybe

11. Are you happy with the appearance of your teeth? ☐ Yes ☐ No ☐ Not Sure/Maybe

12. Do you have any problems with your jaw (clicking, limited movement, pain)? ☐ Yes ☐ No ☐ Not Sure/Maybe

13. Have you ever had an injury to the teeth or jaws or been involved in a motor vehicle accident?
☐ Yes ☐ No ☐ Not Sure/Maybe

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: Date:

Dentist Signature: Date:

DENTIST'S NOTES: