SERENITY DENTAL

DENTAL HISTORY QUESTIONNAIRE

Today's Date: _____

_____ _____

Patient's name Date of Birth

Please answer all the questions below. Check all that apply.

Visit History	Name of previous dentist/dental office:
	How often do you visit the dentist? ☐Never/First visit ☐1-2 per year ☐More than twice a year ☐Irregular ☐Emergencies
	What did you discover about your oral health at your last dental visit?
	What is the most important thing you would like to complete at today's visit?
	When is the last time you had a dental cleaning? ☐6 months ago ☐1-2 years ago ☐Over 2 years ago ☐Never

Current Problem	Are you in any discomfort currently? ☐Yes ☐No If yes, please explain:
	How long has this been bothering you?
	Would you like to have this area treated today?

Appearance	What 3 things would you change about your smile or teeth?
	Of those 3 things, which is the most important to you?
	What are the cosmetic procedures in which you are interested?

Past Experience	Do you have any fears when you visit the dentist? ☐Yes ☐No If yes, please explain:
	Are there any problems with your past dental experiences that you would like to avoid? ☐Yes ☐No Please explain:

General History	Would you like to replace missing teeth, if any?		☐Yes	☐No
	Have you ever had your teeth straightened (orthodontics)?		☐Yes	☐No
	Are your teeth sensitive to (check all applicable):	☐Heat	☐Cold	☐Sweets ☐Air
	Do you feel you have bad breath at times?	☐Yes	☐No	
	Do your gums bleed when you brush or floss?	☐Yes	☐No	
	Have you ever had Gum Treatments?	☐Yes	☐No	
	Does food wedge between your teeth?	☐Yes	☐No	Where?

TMJ/Jaw	Do you grind or clench your teeth?	☐Yes	☐No	Do you have pain in your jaw points?	☐Yes	☐No
	Does your jaw pop or click?	☐Yes	☐No	What side? ☐Right	☐Left	
	Do you feel you have broken or chipped teeth without reason?			☐Yes	☐No	
	Do you wear a night guard?	☐Yes	☐No	Do you get frequent headaches?	☐Yes	☐No
	Has your jaw ever locked open or closed?	☐Yes	☐No	Which?		

My mouth is: ☐Very comfortable ☐Moderately comfortable ☐Uncomfortable

The appearance of my smile is: ☐Excellent ☐Satisfactory ☐Needs improvement ☐Very unsatisfactory

☐I will do anything to keep my teeth healthy and looking great.	☐I have set goals for my oral health with my previous dentist.
☐I want a healthy mouth and teeth, but only what is covered by insurance.	☐I want to set goals for my dental health.
☐I just don't want my teeth to hurt, I don't care about health.	☐I have never thought about goals for my dental health.

Additional comments/questions: