AA - Fort Eustis VA

Medical Information Form

Dental Questionnaire

Dental Questionnaire

Name of Dentist _____

Phone _____

Date of your Last Cleaning _____

Last Exam Date _____

Date of your Last Full Series X-Rays _____

Last Cavity Detection(Bitewing) X-Rays _____

Do your Gums Bleed while Brushing or Flossing ? ☐

Are your teeth Sensitive to Hot, Cold or Sweets ? ☐

Do you get Frequent Fever Blisters, Mouth Ulcers or Sores on your Lips or in your Mouth ? ☐

Have you ever had Burning of the Tongue or Cracking of the Corners of your Mouth ? ☐

Do you Chew/Smoke Tobacco in any form ? ☐

Have you had any Head, Neck or Jaw injuries ? ☐

Do you Notice Popping, Clicking or Soreness of the Jaws or points just in front of the Ears ? ☐

Do you Clench or Grind your teeth ? ☐

Have you ever had Orthodontic Treatment ? ☐

If Yes Date of Placement _____

Do you wear Dentures or Partials ? ☐

If Yes Date of Placement of Dentures ? _____

Are you Happy with your Dentures ? ☐

Are you having any specific problems with your teeth, gums, or mouth at this time ? ☐

Are you Happy with your Smile? ☐

Do you have problems with teeth/fillings breaking ? ☐

Do you regularly use Dental floss ? ☐

Do you have ever been told you have Pyorrhea ? ☐

Do you have difficulty in opening your mouth widely ? ☐

Do you have an Unpleasent taste or Odor in your teeth ? ☐

Does food catch between your teeth ?	☐
Do you want to learn to control your dental disease and retain your teeth ?	☐
Additional Comments	_____
Autism	☐