PERIODONTAL ASSOCIATES 1171 MURRIETA BLVD STE 200 LIVERMORE, CA 94550 (925)449.6633

Name:_____Date_____

Your answers to this dental history questionnaire will help us to understand your specific dental problems so that we may more effectively treat you with consideration for your individual needs. Please answer all questions by circling YES or NO and by checking the appropriate responses.

Yes No Do you presently have pain in your mouth?

Yes No Are you troubled with dryness in your mouth?

Yes No Have you noticed looseness or drifting of your teeth?

Yes No Have you been informed that you have periodontal disease?

Yes No Have you ever had periodontal treatment?

Yes No Have you ever had orthodontic treatment?

Yes No Are you aware of ____ grinding or ____ clenching your teeth?

Yes No Are you aware of ____ popping ____ clicking and/or ____ pain in your jaw?

Yes No Do you have ____ cold sores ____ canker sores on your ____ gums ____ cheeks or ____ lips?

Yes No Have you lost any teeth? If so why?

____ Deep cavities _____ Gum disease ____ Accident ____ Wisdom Teeth ____ Other

If you are missing teeth, what type of replacement do you have?

____ Bridge ____ Partial denture ____ Full denture ____ Dental implant ____ No replacement

Yes No If you wear replacements, are you happy with them?

Yes No Would you be disturbed if you had to lose your teeth?

Yes No Are you dissatisfied with the appearance of your teeth?

Yes No Have you ever had a bad experience in a dental office?

Yes No Are you anxious about dental treatment?

Yes No Would you like sedation during treatment?

Yes No Would you like to learn to control your dental disease to preserve your teeth and oral health?

Date of last dental prophylaxis (cleaning): _____/_____
Month Year

Date of last dental x-rays: _____/_____
Month Year

Remarks:_____

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