HEIM & CARROLL DMD LLC

DENTAL HISTORY QUESTIONNAIRE

Last Name:_____ First Name:_____ Date of Birth_____

1. Do you have a specific dental problem at present?_____
2. Who recommended us to you, or how did you hear about us?_____
3. When was your last dental visit and what was done?_____
4. Who was your last dentist?_____ Town_____ State____
5. Have you ever had:

Full mouth or panoramic x-rays		Yes	No	When_____
Root canal treatment	Yes	No	When_____	
Orthodontic treatment (braces)		Yes	No	When_____
Periodontic Treatment (gumwork)		Yes	No	When_____
Any injuries to your teeth		Yes	No	When_____
Wisdom teeth removed		Yes	No	How many _____
Implants		Yes	No	When _____

6. Do you have any fears or anxieties about dental treatment_____
7. How often do you brush?_____ Floss?_____
8. What kind of toothbrush do you use? (electric, manual) _____
9. Do you use anything else to clean your teeth (toothpick, rubber tip, stimudent)? _____
10. Is there something you like to change about your smile? _____
11. Do you concerns about bad breath? _____
12. Do you clench your teeth? _____
13. Do you wear an oral appliance? (mouth guard, retainer) _____
14. Do you snore? _____
15. Do you have daytime sleepiness or fatigue? _____