New Patient Questionnaire

Health

1. Do you have any allergies?
2. List any medications you currently are taking.
3. Do you smoke or use smokeless tobacco?
4. Have you been told that you snore or stop breathing in you sleep?
5. If so, have you been prescribed a CPAP machine?

Dental History

1. About how long ago was your last cleaning?
2. How often were you being seen?
3. Do you have any dental work not completed?
4. Have you had braces or Invisalign?
5. Have you ever worn a retainer?
6. Have you had your wisdom teeth removed?
7. Are you aware of grinding or clenching your teeth?
8. Do you experience jaw pain, popping or locking?
9. Are your teeth sensitive to hot, cold or bite?
10. Do you suffer from dry mouth?

Home Aids

1. Do you have an automatic or a manual toothbrush?
2. Is it a soft bristle brush?
3. How often do you brush a day?

4. How often do you floss?

Cosmetic

1. Are you aware of your teeth shifting?
2. If so, would you be interested in correcting them?
3. Have you used whitening products to lighten your teeth?
4. Would you be interested in lightening your teeth?

Diet

1. Do you eat/snack on a high amount of carbohydrates per day?

   Bread Crackers Pasta

2. Which of the following do you drink more than once a day?

   Coffee w/sugar Tea w/sugar Juice Soda

   Sports drinks Energy drinks

3. Do you chew gum or eat mints on a daily basis?
4. If yes, are they sugarless?