YQR dental studio

Dental History Questionnaire

Date of last dental visit: ___________________ Date of last dental x-rays taken: ___________________

How often do you brush and floss?

Brush: ____________________ Floss: ____________________

Is there anything you would like to change about the appearance of your teeth?

Shape: Y or N _______________________ Color: Y or N ____________________

Missing teeth/spaces: Y or N _______________________

Do you have any of the following:

Bad breath: Y or N Sensitivity (hot or cold): Y or N Bleeding/ sore gums: Y or N

Do you suffer from any of the following?

Headaches: Y or N ______________________ Jaw clicking or popping: Y or N _____________________

Grinding/clenching: Y or N ________________________

Do you have any other concerns about your dental health? If yes please specify:

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