BARRINEAU D.D.S.
Family Dental Care & Wellness

Name: Date of Birth: Date:

# Dental Questionnaire

**Please circle "Yes" or "No".**

| | | |
|---|---|---|
| Are you currently experiencing dental pain or discomfort? | Yes | No |
| Are you currently experiencing sensitivity to hot or cold? | Yes | No |
| Do you wear partials? Date of placement: | Yes | No |
| Do your gums bleed when you brush or floss? | Yes | No |
| Are your teeth sensitive to cold, hot, sweets or biting? | Yes | No |
| Does food or floss catch between your teeth? | Yes | No |
| Is your mouth excessively dry? | Yes | No |
| Have you had periodontal (gum) surgery? | Yes | No |
| Have you had orthodontic (braces) treatment? | Yes | No |
| Have you had problems associated with previous dental treatment? | Yes | No |
| Are you apprehensive about dental care? | Yes | No |
| Do you have frequent sore throats? | Yes | No |
| Do you experience earaches or neck pain? | Yes | No |
| Do you have any clicking, popping, or discomfort in jaw? | Yes | No |
| Do you have any difficulty chewing or opening and closing? | Yes | No |
| Do you clench or grind your teeth? | Yes | No |
| Do you get sores or ulcers in your mouth? | Yes | No |
| Have you ever had a serious injury to your face, jaw, teeth, or mouth? | Yes | No |

| | | |
|---|---|---|
| Oral habits:<br>- Thumb/finger habit?<br>- Lip/nail biting habit?<br>- Use of pacifier? | <br>Yes<br>Yes<br>Yes | <br>No<br>No<br>No |
| Do you currently wear a night guard? | Yes | No |

| | | |
|---|---|---|
| Do you like the shape, color, and length of your teeth? | Yes | No |
| Would you like your teeth whiter? | Yes | No |
| Would you like your teeth straighter, or spaces closed between your teeth? | Yes | No |
| Do you have missing teeth you would like replaced? | Yes | No |
| Do you have any silver fillings that you would want replaced with tooth-colored fillings? | Yes | No |

**Smile Evaluation**

** If you could change anything about your smile, what would you change?

**Sleep Apnea Evaluation**

| | | |
|---|---|---|
| Do you snore loudly? (Loud enough to be heard behind closed doors?) | Yes | No |
| Do you often feel tired, fatigue, or sleepy during the day? | Yes | No |
| Has anyone observed you stop breathing during your sleep? | Yes | No |
| Is your body mass index greater than 28? | Yes | No |