ADULT

Name______________________________ Date________________

It is our goal to educate our patients on proper dental care, overall health and nutrition. In order to do so, we ask you to please fill out this questionnaire. This questionnaire is designed to aid us in identifying any habits that lead to dental related problems and to educate you, in order to prevent disease and achieve the best oral health.

1. Are there any special diets followed by you or any family members? **Yes / No**
   If so, does that affect your food intake? **Yes / No**
2. Would you say your diet is *good, fair* or *poor*?
3. List any vitamin supplements that you take____
4. Do you frequently consume foods high in sugars? **Yes / No**
5. Do you snack between meals? **Yes / No**
   Examples:
6. Do you sip on a drink throughout the day? **Yes / No**
   Examples:
7. Do you drink alcohol more than 3 times per week? **Yes / No**
8. Do you chew on gum or suck on mints regularly? **Yes / No**
9. Do you frequently have dry mouth? **Yes / No**
10. Do you take any meds that cause dry mouth? **Yes / No**
11. Do you use tobacco products? **Yes / No**
12. Do you breathe through your *mouth* or *nose*? (Circle one)
13. Do you have fluoride in your water at home? **Yes / No**
14. How often do you brush? ______per__________ Floss? _____per________
15. Are your teeth sensitive to *hot, cold* or *certain foods*? **Yes / No**
16. Has anyone ever told you that you have gum disease? **Yes / No**
17. Has anyone in your immediate family been treated for gum disease? **Yes / No**
18. Have you had any fillings in the last 3 years? **Yes / No**
19. Has anyone in your immediate family had fillings in the last 3 years? **Yes / No**
20. Have you had braces in the past? **Yes / No**
21. Are you undergoing Chemotherapy or Radiation Treatments? **Yes / No**
22. Have you been told that you snore in your sleep? **Yes / No**
23. Have you been told you have sleep apnea? **Yes / No**
24. Do you currently use or have you used in the past a C-PAP machine? **Yes / No**
25. Are you tired, fatigued or sleepy most days? **Yes / No**
26. What are the long term goals for your dental health?________________________________
    ____
27. Do you wish to change anything about your smile? _______________________________
    ____