AT HOME DENTAL

Pre Visit Questionnaire

Name:	DOB:

1. Reason for visit:

Is there a specific reason you have made this appointment above and beyond pre-planned treatment or a regular dental health check? Please give brief description.

2. Suffering from dental pain:	**YES/NO** (if NO go to Q3)
Where about is it hurting?	
Is the pain short or long lasting?	
Is it spontaneous pain or brought on by hot, cold or eating?	
If it is long lasting what relieves the pain?	
How often are you in pain?	
3. Broken teeth:	**YES/NO** (if NO go to Q4)
Is it painful?	
What's the location in the mouth?	
How long has it been broken?	
Is it causing painful rubbing on the tongue or cheeks?	
4. Dental Hygiene:	
Do you think your teeth require a professional clean?	**YES/NO**
Are you suffering from bad breath?	**YES/NO**
Do you use a manual or electric toothbrush?	**ELECTRIC/MANUAL/BOTH**
Do you use any other cleaning aids such as floss or interdental brushes?	**YES/NO**
Do you use Fluoride toothpaste?	**YES/NO**
5. Appearance and function	
Can you eat what you want and not limited by your oral condition?	**YES/NO**
If no what do you think the problem is – loose teeth, gaps or pain? Please describe.	
Are you happy with the appearance of your teeth?	**YES/NO**
If not describe what you are unhappy with – colour,shape,gaps?	
6. Do you have dentures?	**YES/NO** (if NO go to Q7)
How long have you been wearing dentures?	
How old are your current set?	
Are they comfortable and do they work well?	**YES/NO**
If not please describe.	
Would you be interested in having your dentures sent off to be professionally cleaned?	**YES/NO**
Would you like a new set of dentures?	**YES/NO**
7. Any additional information or any other requests?	
8. Is there anything we need to know about your home? e.g. pets, accessibility, any steps, parking	z