GCHC Dental Tooth Questionnaire

Patient Name ___________________________ Date ______________

When was your **last** dental visit?______________________________________

Are you aware of clenching or grinding your teeth while awake or asleep?
- Yes
- No

Have you ever been treated for TMJ problems?
- Yes
- No

Have you ever had orthodontic treatment?
- Yes
- No

Have you ever been told you need orthodontic treatment?
- Yes
- No

Have you ever been told that you need medication prior to dental procedures?
- Yes
- No

Do you brush your teeth?
- Yes *How often?*_______________
- No

Do you floss your teeth?
- Yes *How Often?* _____________
- No

Do you use fluoride toothpaste?
- Yes
- No

Do you eat mostly at meal times? (breakfast, lunch, dinner) and/or do you snack?

____

How often do you drink soda, energy drinks, Gatorade, or juice?

____