

PERIODONTAL QUESTIONNAIRE

Because every question asked here may relate directly or indirectly to the diagnosis and treatment of gum disease, we thank you for responding as honestly and completely as possible to the following questionnaire.

NAME _____ **DATE** _____

WHEN WERE YOUR TEETH LAST CLEANED PROFESSIONALLY? _____

HOW OFTEN DO YOU USUALLY HAVE A "CLEANING"? _____

HAVE YOU EVER HAD AN ACUTE, PAINFUL GUM INFECTION? Yes No
If Yes, When? (Circle any that apply) Child / Teen / Adult

HAVE YOU EVER BEEN TOLD YOU HAVE GUM DISEASE? Yes No
If Yes, Approximate Year Gum Disease Was First Discovered: _____

IF GUM DISEASE WAS DIAGNOSED, HAS ANY TREATMENT EVER BEEN DONE? Yes No

IF YES Please Complete The Following:

MY TREATMENT WAS: Surgical / Non-Surgical

IF SURGICAL, WERE ALL TEETH TREATED OR JUST SPECIFIC AREAS?

Full Mouth / Specific Areas _____

IF NON-SURGICAL, PLEASE DESCRIBE TREATMENT:

Deep cleaning? Root planing? Number of visits? Was anesthetic used?

WHAT WERE THE RESULTS OF YOUR SURGICAL OR NON-SURGICAL TREATMENT?

HOW OFTEN DID YOU SEE THE DENTIST OR HYGIENIST AFTER TREATMENT WAS COMPLETED?

Once Every 2 3 4 6 12 Months

FOR HOW LONG DID YOU KEEP THIS ROUTINE? _____

IF NO Please Explain Why You Decided Not To Have Treatment Done:

HAS YOUR GUM DISEASE BEEN TREATED MORE THAN ONCE? Yes No
If Yes, Please Describe Treatment And Year:

_____ 19 _____

HAVE YOU EVER LOST ANY TEETH TO GUM DISEASE? Yes No

HAS YOUR SPOUSE, "SIGNIFICANT OTHER", OR ANY MEMBER OF YOUR FAMILY EVER HAD GUM DISEASE? Yes No

Relationship: _____

DO YOUR GUMS EVER BECOME: Tender Red Swollen

DO YOUR GUMS EVER BLEED? Yes No
If So, When Do They Bleed? Brushing Flossing Other

DO YOU HAVE A "BAD TASTE" IN YOUR MOUTH? Frequently Occasionally Never

DO YOU EVER GRIND OR CLENCH YOUR TEETH? Yes No

ARE YOU TROUBLED BY FREQUENT HEADACHES? Yes No

DOES YOUR JAW EVER GET SORE, CLICK, OR POP? Yes No

HAVE YOU NOTICED THAT YOUR TEETH ARE SHIFTING POSITION, OR THAT SPACES ARE DEVELOPING BETWEEN YOUR TEETH? Yes No

If Yes, Where? _____

IS "FOOD WEDGING" A PROBLEM WHEN YOU CHEW? Yes No
If Yes, Where? _____

ARE ANY OF YOUR TEETH HOT OR COLD SENSITIVE? Yes No

ARE ANY OF YOUR TEETH LOOSE? Yes No

DO ANY OF YOUR TEETH HURT WHEN YOU BITE DOWN? Yes No

WHAT KIND OF TOOTHBRUSH DO YOU USE? Hard Medium Soft
Manual or Electric

HOW OFTEN DO YOU BRUSH EACH DAY? 1 2 3 4 Times
When? Morning Afternoon Evening Bedtime

WHAT KIND OF TOOTHPASTE DO YOU USUALLY USE? _____

DO YOU FLOSS? Frequently Occasionally Never

DO YOU USE ANYTHING ELSE TO CLEAN YOUR TEETH? Yes No
If Yes, Please Describe: _____

HOW DO YOU RATE YOUR GENERAL HEALTH? Excellent Good Fair Poor

APPROXIMATELY HOW MANY TIMES EACH YEAR DO YOU GET SICK? _____ Times
What Type Of Illness Usually? _____

IS YOUR DIET WELL-BALANCED? Yes No

DO YOU TAKE REGULAR VITAMIN / MINERAL SUPPLEMENTS? Yes No
What Kind? _____

ARE YOU AWARE OF ANY HORMONE IMBALANCES? Yes No

IS ANYONE IN YOUR FAMILY DIABETIC? Yes No

ARE YOU BORDERLINE DIABETIC? Yes No

DO YOU SMOKE TOBACCO REGULARLY NOW? Yes No
How Much Do You Smoke: _____ pack per day
How Long Have You Smoked? _____ years

IF YOU DON'T SMOKE NOW, BUT **DID** SMOKE IN THE PAST
How Much Did You Smoke? _____ pack per day
How Long Did You Smoke? _____ years
When Did You Quit Smoking? _____ approximate year
Why Did You Quit Smoking? _____

HAVE YOU BEEN UNDER AN UNUSUAL AMOUNT OF STRESS LATELY? Yes No
If Yes, How Long? _____

HAVE YOU TAKEN AN ANTIBIOTIC MEDICATION FOR ANY REASON WITHIN THE PAST THREE MONTHS? (sinus infection, ear infection, strep throat, etc.) Yes No
If Yes, When? _____
Reason For Antibiotic: _____
Type Of Antibiotic: _____
How Long Did You Take It? _____