Brookview Dental Care

NEW PATIENT QUESTIONNAIRE

We ask you for information about your lifestyle to help us treat you. All information will be kept strictly confidential by the people caring for you.

TITLE	SURNAME	FORENAMES	DATE OF BIRTH
			/ /

QUESTIONS RELEVANT TO YOUR DENTAL HEALTH	YES	NO	DETAILS
1.Do you have any pain in your teeth and gums ?			
2. Do your gums bleed ?			
3. Are you happy with the appearance of your teeth ?			
4. Are you concerned about bad breath (halitosis) ?			
5. Do you grind your teeth at night ?			
6.Do you suffer from headaches or migraines ?			
7. Do you take sugar in your tea of coffee ?			
8.Do you drink a lot of fizzy drinks ?			
9.Do you chew gum ?			
10. Do you play a contact sport eg Hockey, Squash, Rugby or Football ?			
11. Do you wear a sports mouthguard ?			
12. Is your toothbrush electric ?			
13.Do you use dental floss regularly ?			
14. Do you use a mouthwash regularly ?			
15. Do you use any other cleaning methods eg Interdens, toothpicks or interdental brushes ?			
16. Do you use a water jet device eg Water-Pik, Kitty Water Jet or Braun Irrigator ?			
17. Do you smoke ?			

We need to know if you have any particular worries about, or problems with dental treatment so that we can help you cope with these.
Please gives details of any previous difficulties you have had in the past when receiving treatment at the dentist.

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