NEHALEM BAY
HEALTH CENTER & PHARMACY
COMPASSIONATE COMMUNITY CARE
885 Nehalem Blvd | PO Box 176 | Wheeler, OR 97147 | 1-800-368-5182 | Fax: 1-844-712-3001 | nehalembayhealth.org

Dental History Questionnaire

Patient Name: _____ **Date:** ____ / ____ / _____

When was your last dental visit?

Within 6 months 6-12 months ago More than 1 year ago I do not remember

Name of previous provider? _____

Do you currently have any of the following? (circle all that apply)

Tooth pain
Sensitivity to hot or cold
Sensitivity when biting
Bleeding gums
Swollen or tender gums
Bad breath
Loose teeth
Food getting caught between teeth
Dry mouth
Jaw pain
Clicking or popping in jaw
Clenching or grinding teeth
Difficulty opening mouth
Frequent headaches
Mouth sores
Obstructive sleep apnea (CPAP YES / NO)
Other concerns: _____

Previous Dental Problems

Have you ever had any of the following?

Gum disease / periodontal treatment
Deep cleanings (scaling and root planing)
Orthodontic treatment (braces / aligners)
Dental implants
Oral surgery
TMJ treatment
Complications from dental treatment

If yes, please explain:

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Dental Anxiety

How do you feel about dental treatment?

No Mild Moderate Severe

Oral Health Habits

How often do you brush your teeth?

Once daily
Twice daily
More than twice daily
Occasionally

How often do you floss?

Daily
Sometimes
Rarely
Never

Do you use any additional oral hygiene aids? (circle all that apply)

Mouthwash
Water flosser
Interdental brushes
Toothpicks
Electric toothbrush

Lifestyle Factors

Do you use tobacco?

YES / NO
type: _____

Do you vape?

YES / NO

Do you frequently consume sugary drinks or snacks?

YES / NO

Patient Goals

What would you like to improve about your smile or oral health?

Whiter teeth
Healthier gums
Straighter teeth
Replace missing teeth
Improve overall oral health
Other: _____

Is there anything about your dental health that you would like us to know?

Patient Signature

I confirm that the information provided is accurate to the best of my knowledge.

Patient or Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____