Pre-appointment questionnaire

Have you noticed any of the following?			Is this new since your last visit?		
Tooth sensitivity to cold or hot food/drinks	○ Yes	○ No		○ Yes	○ No
Pain while biting down	○ Yes	○ No		○ Yes	○ No
Plaque buildup	○ Yes	○ No		○ Yes	○ No
Tooth stains or discoloration	○ Yes	○ No		○ Yes	○ No
Changes to the look of your gums	○ Yes	○ No		○ Yes	○ No
Gum pain before/after brushing	○ Yes	○ No		○ Yes	○ No
Gum bleeding before brushing or flossing	○ Yes	○ No		○ Yes	○ No
Bad breath	○ Yes	○ No		○ Yes	○ No

What is your current oral care routine?

How many times a day do you usually brush? ○ Once ○ Twice ○ Three or more

Do you floss daily? ○ Yes ○ No

What do you use to floss? ○ String floss ○ Floss picks ○ Water flossers ○ Other

Do you use mouthwash daily? ○ Yes ○ No

What is your top goal to improve your oral health? Check all that apply.

- ○ Improve my smile
- ○ Whiten my teeth
- ○ Keep my teeth healthy
- ○ Reduce my pain sensitivity
- ○ Replace missing teeth
- ○ Healthier gums
- ○ Straighten my teeth
- ○ Other _____

Do you feel like your routine is helping you reach your goal?

○ Yes ○ No ○ Partially ○ Maybe

What is the biggest challenge to following your oral care routine? Check all that apply.

- ○ I don't have enough time
- ○ I can't physically do it with the tools I have
- ○ I don't feel like I need to
- ○ I don't enjoy using mouth-wash, brushing or flossing
- ○ I don't have the motivation
- ○ Other _____

Do you have any other concerns or goals you would like to talk about today?

_____

_____

Please share this questionnaire with your dental professional during today's appointment.

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