**Dr. D. R. Jurasek Inc.**

Office Phone: 250 833-1005
Home Phone: 250 804-9569
Email: Jurasek@shuswapdental.com

# Dental Questionnaire:

Please take the time to read and fill out this form to ensure your dental history is known prior to your appointment.

Patient Name: _____

Today's Date: (Month/Day/Year): _____/____/_____

## Questions:

1. Reason for visit today: _____

_____

_____

_____

_____

2. When was your last dental treatment and what was done? Date: _____/____/_____

_____

_____

_____

3. Frequency of dental visits: _____

_____

4. Previous dentist (if applicable): Name: _____

Location: _____ Date: _____/____/_____

5. Have you had a dental films/ x-rays taken recently? ..... ☐ Yes ☐ No

Which dental office: _____ When: _____/____/_____

May we request a copy of them?..... ☐ Yes ☐ No

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6. For the following questions 7-26, please answer yes or no:

| | | |
|---|---|---|
| 7. Do your gums bleed while brushing or flossing?…….. | ☐ Yes | ☐ No |
| 8. Are your teeth sensitive to hot or cold?……. | ☐ Yes | ☐ No |
| 9. Are your teeth sensitive to sweets or sour?…..…….. | ☐ Yes | ☐ No |
| 10. Do you feel pain in any of your teeth?…… | ☐ Yes | ☐ No |
| 11. Do you have any sores or lumps in or near your mouth?…… | ☐ Yes | ☐ No |
| 12. Have you ever had any head, neck or jaw injuries?…… | ☐ Yes | ☐ No |
| 13. Have you ever experienced any of the following problems in your jaw? | | |
| 14. Clicking …… | ☐ Yes | ☐ No |
| 15. Pain (joint, ear or side of face)…… | ☐ Yes | ☐ No |
| 16. Difficulty in opening/closing…… | ☐ Yes | ☐ No |
| 17. Difficulty in chewing…… | ☐ Yes | ☐ No |
| 18. Do you have frequent headaches?…… | ☐ Yes | ☐ No |
| 19. Do you clench or grind your teeth?…… | ☐ Yes | ☐ No |
| 20. Do you bite your lips/cheeks frequently?…… | ☐ Yes | ☐ No |
| 21. Have you noticed any loosening of your teeth?…… | ☐ Yes | ☐ No |
| 22. Does food get caught between your teeth?…… | ☐ Yes | ☐ No |
| 23. Have you had periodontal (gum) treatment?…… | ☐ Yes | ☐ No |
| 24. Have you received oral hygiene instructions for the care of your teeth and gums?…… | ☐ Yes | ☐ No |
| 25. Have you had difficult dental extractions in the past?…… | ☐ Yes | ☐ No |
| 26. Have you had prolonged bleeding following extractions in the past? ……..…….. | ☐ Yes | ☐ No |

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27. Do you wear dentures or partials? ..... ☐ Yes ☐ No

If yes, placement date: (Month/Day/Year) _____/____/_____

28. Do you have dental implants? ..... ☐ Yes ☐ No

If yes, placement date: (Month/Day/Year) _____/____/_____

29. Have you had orthodontic treatment? ..... ☐ Yes ☐ No

If yes, date of completing: (Month/Day/Year) _____/____/_____

30. Have you had treatment from a dental specialist? ..... ☐ Yes ☐ No

If yes, what type: _____

_____

_____

_____

31. Additional comments or concerns? _____

_____

_____

_____

_____

_____

_____

_____

_____

After completing this form online, please save it to your computer and upload it at our website www.drjurasek.com or print it out and bring it in at your next appointment.

**Signature of patient/guardian**: _____