Oral Health Assessment Patient Questionnaire

Patient: **Our ref:**

Patient focus

Section 1		**Tick**
1.1 In the past have dentist regularly?	Yes	
	No	
1.2 How do you feel about going to the dentist	Very nervous	
	A little nervous	
	Not nervous at all	
1.3 What are your particular concerns regarding your teeth	Relief of pain only	
	Maintain healthy teeth/mouth	
	Appearance of teeth/cosmetic treatments	

Section 2	**Tick or circle**	**Additional notes**
2.1 Are you satisfied with your recent dental treatment?	Yes	
	No	**Why not?**
2.2 Was your treatment explained to you before it was carried out?	Yes	
	No	
2.3 Were alternative treatment options discussed with you?	Yes	
	No	
2.4 Were you given a written estimate of proposed treatment costs?	Yes	
	No	
2.5 Was any treatment during your last course of treatment provided under private contract?	Yes	**What treatment was this?**
	No	
2.6 Have you declined any treatment recommended by your dentist?	Yes	**What treatment was this?**
	No	

Clinical and cost effectiveness **Our Ref:**

Section 3 **Questions to be asked as appropriate**	**Tick or circle**	**Tick is patient has been advised regarding this**	**Comments/primary prevention required**
3.1 Do you take sugar in tea or coffee?	Yes/No		
3.2 Do you drink fizzy drinks?	Yes/No		
3.3 If you have some natural teeth, how often do you clean them?	Never		
	Sometimes		
	At least once per day		
3.4 Do you floss your teeth or use any other form of interdental cleaning?	Never		
	Sometimes		
	At least once per day		
3.5 Do you smoke or use tobacco in any form?	Yes/No		
3.6 If you wear dentures, how often do you clean your dentures?	Never		
	Sometimes		
	At least once per day		
3.7 If you wear dentures, do you wear them at night?	Yes/No		
3.8 Has any member of your family lost teeth at a young age due to periodontal disease?	Yes/No		
3.9 Do you participate in any contact sports?	Yes/No		

Confidential medical questionnaire **Our ref:**

	Yes	No	Don't know
Have you ever had: • **Rheumatic fever or St. Vitus dance?**			
• **Infective Endocarditis?**			
• **Heart surgery?**			
Do you have: • **A heart murmur?**			
• **Damaged or artificial heart valves?**			
• **Any other heart problem?**			
Have you had an artificial joint replacement, e.g hip or knee?			
Do you have: • **Epilepsy?**			
• **Diabetes?**			
• **Asthma?**			
• **Allergies?**			
Do you take any tablets or medicines regularly?			
Have you had any other serious medical condition not covered by the questionnaire?			
For DRO use only:			