Elica Health Centers
Dental History Questionnaire

Patient's Name:	DOB:	MRN:	Today's Date:

1.	Are you currently experiencing dental pain? If YES, please explain:	☐ Yes	☐ No	☐ Unknown
2.	When was your last Dental Exam?	Date:		☐ Unknown
3.	Do you have difficulty opening your mouth?	☐ Yes	☐ No	☐ Unknown
4.	Do you have difficulty chewing?	☐ Yes	☐ No	☐ Unknown
5.	Does your jaw click, pop, or lock open? If YES, please explain:	☐ Yes	☐ No	☐ Unknown
6.	Do you have any history of sores or growth in your mouth?	☐ Yes	☐ No	☐ Unknown
7.	Do you clench or grind your teeth?	☐ Yes	☐ No	☐ Unknown
8.	Do you have dry mouth?	☐ Yes	☐ No	☐ Unknown
9.	Are your teeth sensitive to hot or cold? If YES, please explain:	☐ Yes	☐ No	☐ Unknown
10.	Do your gums bleed when you brush or floss your teeth?	☐ Yes	☐ No	☐ Unknown
11.	Does dental treatment make you nervous?	☐ Yes	☐ No	☐ Unknown
12.	Have you had any serious injury with your face or mouth? If YES, please explain:	☐ Yes	☐ No	☐ Unknown
13.	Have you ever had problems with dental treatment or dental anesthetic? If YES, please explain:	☐ Yes	☐ No	☐ Unknown

For Patients Age 0 to 17 - Caries Risk Assessment

14. Does your child receive fluoride from any of the following sources?

    Check all that apply: ____ Supplement ____ Fluoridated Water ____ Toothpaste ____ Fluoride Rinse ____ None

15. Does your child suck his/her thumb, fingers, or pacifier? ☐ Yes ☐ No ☐ Unknown

16. Does your child go to bed with a bottle or cup with anything other than water (such as milk or juice)? ☐ Yes ☐ No ☐ Unknown

    If YES, please explain:

17. How many times a day does your child have sugary foods or drinks (juice, carbonated or non-carbonated soft drink, energy drinks, medicinal syrups)? _____ times a day

18. Does anyone in the household have existing or pending dental restoration (fillings, crowns...)? ☐ Yes ☐ No ☐ Unknown

19. Does the patient have any special healthcare needs (developmental delay, physical, medical or mental disabilities that prevent or limit performance of adequate oral healthcare by themselves or a caregiver)? ☐ Yes ☐ No ☐ Unknown

20. Does the patient have any eating disorder? ☐ Yes ☐ No ☐ Unknown

For Women - OB/GYN History

21. Are you currently pregnant? ☐ Yes ☐ No ☐ Unknown

    If YES, what is your estimated due date:

22. Are you currently breastfeeding? ☐ Yes ☐ No