antigo DENTAL clinic
Dr. Meghan K. O'Brien

Questionnaire

NAME: _____ DATE:_____

Please check which statements apply:

- ○ I want my teeth to be whiter
- ○ I want my teeth to be straighter
- ○ I do not like the way my teeth come together
- ○ I think my teeth are too long or too short
- ○ I have chips or uneven edges on my teeth
- ○ I want to replace missing teeth
- ○ I would like to replace old fillings or other dental work
- ○ I avoid smiling when I have my picture taken
- ○ I had no fluoride in my drinking water as a child
- ○ I have no fluoride in my drinking water now
- ○ I drink filtered or bottled water
- ○ I have receding gums or history of gum disease
- ○ I have a strong family history of dental decay
- ○ I have dry mouth, take medications that cause dry mouth or breathe through my mouth
- ○ I currently wear orthodontic braces
- ○ I have sensitivity to hot, cold or biting
- ○ I use home whitening products
- ○ I have limited hand dexterity
- ○ I use chewing gum, lozenges, breath mints or hard candy with sugar between meals
- ○ I do not visit my dental office regularly
- ○ I am currently undergoing or have a history of chemo or radiation therapy
- ○ I have acid reflux
- ○ I have teeth that trap food or don't feel clean
- ○ I have had dental work in the past year
- ○ I snack frequently between meals
- ○ I sip on beverages throughout the day excluding water
- ○ I use tobacco products of any type
- ○ I grind teeth frequently
- ○ I floss less than once per day