



# NEXT DIMENSION DENTISTRY

DR. BRENT FAIRBANKS / DR. TROY MICHELSON

## Hygiene Questionnaire

*Please answer the following questions to enable us to better understand your dental needs and return it to the hygienist.*

**Yes No**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Take a few moments to run your tongue around your teeth. Do you notice any chipped, broken or cracked teeth or fillings?                 |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Remembering the last time you ate or drank anything hot, cold or sweet, did any of your teeth hurt because of the temperature or sweets? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you clench or grind your teeth?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you wake up with sore teeth, jaws, headaches or neck aches?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. When you chew your food, do you tend to favour one side?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Have you ever noticed any change in the way your teeth fit together when you bite?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. When you brush your teeth, do you ever notice that your toothbrush has a pink tint to it, or do you ever notice your gums bleeding?      |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you feel like you have bad breath, or have you ever had a bad taste in your mouth that keeps recurring?                               |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Is there anything about the size, shape or colour of your teeth that you would like to change?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Are you currently using a power toothbrush?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. What other concerns do you want to discuss during this visit?   |