DENTAL HYGIENE QUESTIONNAIRE

Practice Name: [Your Practice Name]

Address: [Practice Address] | Phone: [Practice Phone]

Generated: 7/9/2025

DENTAL HYGIENE QUESTIONNAIRE

Patient Name: [Patient Name]
Date: [Date]
Patient Code: [Patient Code]

ORAL HYGIENE ROUTINE

1. How often do you brush your teeth?
☐ Once a day ☐ Twice a day ☐ Three times a day ☐ More than three times

2. What type of toothbrush do you use?
☐ Manual soft ☐ Manual medium ☐ Manual hard ☐ Electric

3. How long do you brush your teeth?
☐ Less than 1 minute ☐ 1-2 minutes ☐ 2-3 minutes ☐ More than 3 minutes

4. Do you floss regularly?
☐ Daily ☐ Few times a week ☐ Weekly ☐ Rarely ☐ Never

5. What type of floss do you use?
☐ Traditional floss ☐ Floss picks ☐ Water flosser ☐ Interdental brushes

6. Do you use mouthwash?
☐ Daily ☐ Few times a week ☐ Weekly ☐ Rarely ☐ Never

ORAL HEALTH SYMPTOMS

7. Do you experience bleeding gums?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

8. Do you have tooth sensitivity?
☐ None ☐ Mild ☐ Moderate ☐ Severe

9. Do you grind your teeth or clench your jaw?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

10. Do you wake up with jaw pain or headaches?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

DENTAL HISTORY

11. When was your last dental cleaning?
☐ Within 6 months ☐ 6-12 months ago ☐ 1-2 years ago ☐ Over 2 years ago

12. How do you rate your current oral health? (1-10 scale): _____

13. What are your main oral health concerns?
_____
_____

14. Additional comments:

Patient Signature: _____ Date: _____

For Office Use:
Hygienist Notes: _____
Recommendations: _____
Next Appointment: _____