Dental Patient Questionnaire Booklet

1. Dental Nutritional Questionnaire

Patient name: _____ Date: _____

Age: _____ Filled in by: [ ] Patient [ ] Parent [ ] Caregiver

Section 1: Daily Eating & Drinking Habits

1. How many times do you eat or drink (anything besides water) in a day?

[ ] 1-3 [ ] 4-5 [ ] 6-7 [ ] More than 7 !

2. What time is your first food or drink of the day? _____

3. What time is your last food or drink of the day (excluding water)? _____

Section 2: Drinks During the Day

4. Which of these do you usually drink (tick all that apply):

[ ] Water [ ] Coffee [ ] Tea [ ] Milk [ ] Soft drinks [ ] Fruit juice

[ ] Energy drinks [ ] Flavored water [ ] Other: _____

5. Do you add sugar or syrup to any drinks? [ ] Yes [ ] No

If yes, which drinks? _____

6. How many sugary drinks do you usually have per day?

[ ] 0 [ ] 1 [ ] 2 [ ] 3 or more !

Section 3: Food Habits

7. Do you often eat sweet snacks? [ ] Yes [ ] No How many times a day? _____

8. Do you often eat acidic foods? [ ] Yes [ ] No How many times a day? _____

9. Do you chew gum or use mints? [ ] No [ ] Sugar-free [ ] With sugar !

10. Do you eat or drink during the night? [ ] Yes ! [ ] No

Section 4: Additional Notes (Optional)

11. Do you follow any special diet? [ ] No [ ] Yes: _____

12. Comments: _____

Tip: Try to stay at or below 7 eating/drinking moments per day.

Water is always safe for your teeth!

2. Dental Hygiene Questionnaire

Section 1: Brushing Habits

1. How often do you brush your teeth? [ ] <1x/day ! [ ] 1x/day [ ] 2x/day (x) [ ] >2x/day

2. When do you brush? [ ] Morning [ ] After lunch [ ] Before bed [ ] Other: _____

3. How long do you brush? [ ] <1 min ! [ ] 1-2 min [ ] 2-3 min (x) [ ] >3 min

4. Electric toothbrush? [ ] Yes [ ] No [ ] Sometimes

5. How old is your brush? [ ] <3 months (x) [ ] 3-6 months [ ] >6 months !

Section 2: Additional Oral Care

6. Fluoride toothpaste? [ ] Yes (x) [ ] No [ ] Don't know

7. Floss/interdental cleaning? [ ] No [ ] Occasionally [ ] Daily (x)

8. Mouthwash? [ ] No [ ] Occasionally [ ] Daily - When? _____

9. Clean your tongue? [ ] No [ ] Yes ([ ] Toothbrush [ ] Scraper)

Section 3: Dental Visits & Habits

10. Last dental check-up? [ ] <6 months (x) [ ] 6-12 months [ ] >1 year ! [ ] Never !

11. Do you smoke or vape? [ ] No (x) [ ] Yes: [ ] Cigarettes [ ] Vape [ ] Other

12. Gums bleed when brushing? [ ] No (x) [ ] Occasionally [ ] Often !

13. Bad breath often? [ ] No [ ] Yes [ ] Don't know

14. Do you wear: [ ] Braces [ ] Nightguard [ ] Denture [ ] Retainer - Cleaned daily? [ ] Yes [ ] No

Section 4: Concerns or Questions

15. Any concerns? [ ] No [ ] Yes: _____

16. Anything you'd like to improve? _____

3. Erosive Tooth Wear Questionnaire

Dental Patient Questionnaire Booklet

Section 1: Eating & Drinking Habits

1. Frequency of acidic drinks per day? [ ] Rarely [ ] 1-2x [ ] >=3x !

2. Sip slowly or hold in mouth? [ ] No [ ] Yes !

3. Eat acidic foods daily? [ ] Rarely [ ] Sometimes [ ] Daily !

4. Brush right after acids? [ ] No (x) [ ] Yes !

Section 2: Health & Habits

5. Acid reflux/heartburn/vomiting? [ ] No [ ] Occasionally [ ] Often !

6. Medication causing dry mouth? [ ] No [ ] Yes - Name: _____

7. Grind or clench teeth? [ ] No [ ] Yes - [ ] Night [ ] Day

Section 3: Noticed Changes

8. Any of the following? (check all that apply)

[ ] Sensitivity [ ] Thinner/shorter teeth [ ] Yellowing [ ] No changes

Tip: Avoid brushing immediately after acids. Limit acidic exposure.

4. Oral Health Behavior & Awareness

1. Do you feel confident in your current oral hygiene routine? [ ] Yes [ ] No

2. Do you know how diet affects your teeth? [ ] Yes [ ] No

3. Do you feel your dental health has changed in the past year? [ ] Improved [ ] Same [ ] Worse

4. How often do you experience tooth pain or discomfort? [ ] Never [ ] Occasionally [ ] Often

5. What would you like to learn more about? (tick any)

[ ] Proper brushing/flossing [ ] Diet and dental health [ ] Preventing gum disease [ ] Sensitivity management

Your input helps us support your dental health better!