**PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE RESPONSE OR FILLING IN THE BLANK.**

1. **In the past two years, have you had any of the following symptoms?** *(If YES, please check all that apply.)*
   - Sensitive teeth
   - Sore jaw
   - Toothache
   - Sore gums
   - Bleeding gums
   - Difficulty chewing
   - Filling fell out
   - Dry mouth
   - Bad breath
   - Burning sensation
   - Abscess
   - Swollen face
   - Swelling inside mouth
   - Tartar buildup
   - Broken teeth
   - Difficulty swallowing
   - Sore jaw
   - Difficulty chewing
   - Burning sensation
   - Abscess
   - Swollen face
   - Sore gums
   - Dry mouth
   - Toothache

   **Comments:**

2. **In the past two years, how many times have you been to a dental office for:**
   - Checkups and cleanings
   - Date of last cleaning:

   **Check any dental treatment you have had in the last two years:**
   - Fillings
   - Dental emergency
   - Bridges
   - Implants
   - Crowns (caps)
   - Gum treatment
   - Dentures

3. **When did you last have dental x-rays taken?**

4. **Do you clench or grind your teeth?**
   - Yes
   - No
   - If YES, during the day?
   - At night?
   - If YES, do you wear a bite guard?
   - For how long?
   - Don’t wear it

5. **In the past two years, have you been concerned about the appearance of your teeth?**
   - Yes
   - No
   - Yellowing/graying teeth
   - Stains
   - Crowded, crooked teeth
   - Spacing between teeth
   - Other:

6. **Has anyone in your family lost teeth?**
   - Yes
   - No

7. **Check any of the following you regularly use at home:**
   - Soft toothbrush
   - Dental floss
   - Floss threader
   - Fluoride supplements tabs or drops
   - Hard toothbrush
   - Special brush
   - Toothpick
   - Powered interdental cleaner
   - Medium toothbrush
   - Fluoride toothpaste
   - Fluoride rinse or gel
   - Powered brush
   - Oral irrigator
   - Rubber tip
   - Mouth rinse
   - Other:
   - Denture adhesive
   - Denture cleanser
   - Whitening product

8. **Check the type of toothpaste you use:**
   - Fluoride
   - Tartar control
   - Gum benefit
   - Whitening
   - Sensitivity protection
   - Baking soda
   - Peroxide
   - Multiple benefit

9. **How long does it take you to clean your teeth and gums?**
   - Brushing time
   - Flossing or between teeth cleaning time

10. **How many times each day/week do you brush and floss?**
    - I brush about __________ times per day.
    - I floss about __________ times per day.

11. **Do you have or have you ever had oral piercings?**
    - Yes
    - No

12. **Is it difficult for you to clean your teeth?**
    - Yes
    - No
    - Hold a toothbrush
    - Use dental floss
    - Brush/floss for any length of
    - Don’t see well

13. **Do you gag easily?**
    - Yes
    - No

14. **Are you on a fluoridated public water system?**
    - Yes, for how long?

15. **Do you drink filtered or bottled water most of the time?**
    - Yes
    - No
    - If YES, what type of filter?
    - For how long?
## BEHAVIORS

1. When your health professional recommends a change in health behavior, do you follow this advice?
   - [ ] YES
   - [ ] NO
   - [ ] Sometimes

2. When you are ill, do you:
   - [ ] See your health care provider?
   - [ ] Seek care in an emergency room?
   - [ ] Wait to see if the condition goes away?

3. Are you nervous or apprehensive about dental treatment?
   - [ ] YES
   - [ ] NO
   - [ ] Somewhat (Explain)

4. Do you feel your stress level has increased in the past six months?
   - [ ] YES
   - [ ] NO
   - [ ] Somewhat (Explain)

5. Do you use tobacco in any form?
   - [ ] YES
   - [ ] NO
   - [ ] Sometimes
   If YES, what type?
   Frequency/Quantity?
   For how long?

6. Do you consume alcohol?
   - [ ] YES
   - [ ] NO
   - [ ] Sometimes
   If YES, what type?
   Frequency/Quantity?

7. Do you consume caffeine?
   - [ ] YES
   - [ ] NO
   - [ ] Sometimes
   If YES, what type?
   Frequency/Quantity?

8. Do you exercise daily?
   - [ ] YES
   - [ ] NO
   - [ ] Sometimes
   If YES, what type?
   Frequency/Quantity?

9. Do you participate in sports/recreation activities?
   - [ ] YES
   - [ ] NO
   - [ ] Sometimes
   If YES, what type?
   Frequency/Quantity?

10. Do you consume any of the following BETWEEN meals? *(Please check all that apply.)*
    - [ ] Breath mints
    - [ ] Cough drops
    - [ ] Chewing gum
    - [ ] Dried fruits
    - [ ] Antacid tablets
    - [ ] Carbonated beverages
    - [ ] Sugared liquids or juice
    - [ ] Chips
    - [ ] Cookies
    - [ ] Other
    - [ ] Crackers

## BELIEFS

How likely do you think you are to have cavities or other problems with your teeth and/or gums?
   - [ ] Very likely
   - [ ] Likely
   - [ ] Less likely
   - [ ] Probably never

How important is it for you to prevent cavities, gum problems or other diseases of the mouth?
   - [ ] Very important
   - [ ] Somewhat important
   - [ ] Not at all important

Would you like your hygienist to make specific product recommendations to meet your oral care needs?
   - [ ] YES
   - [ ] I am not sure
   - [ ] NO

I believe that I have control over the condition of my mouth.
   - [ ] YES, firmly believe
   - [ ] Somewhat believe
   - [ ] NO, do not believe

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<th>STUDENT</th>
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