Cavity Questionnaire

Patient name:

Age:

Do you brush your teeth at least twice a day? Yes No

Do you floss daily? Yes No

Do you use an oral rinse daily? Yes No

Do you have current cavities/decay that needs to be treated/filled? Yes No

Have you had a cavity in the last 3 years? Yes No

Between brushings, do you get visible plaque on your teeth? Yes No

Do you have a dry mouth? Yes No

Do you snack frequently (1-3 times daily)? Yes No

Do you drink acidic or sugary beverages (soda, sports drinks, juices, sweet tea or coffee)? 1-3x/week Yes No

1x/day Yes No

2 or more/day Yes No

Do you have fluoridated water at home? Yes No

General Health Conditions

Do you have special health care needs? Yes No

Have you had chemo/radiation therapy? Yes No

Do you suffer from any kind of eating disorders? Yes No

Do you use any type of tobacco products? Yes No

Are you currently taking any medications that reduces salivary flow? Yes No