

# Tooth Whitening Questionnaire

Copyright: Linda Greenwall

Patient's Name: \_\_\_\_\_

Date : \_\_\_\_\_

I understand that you are interested in having your teeth bleached. Would you kindly complete the details below so that we can help you to achieve successful whitening of your teeth and a happy smile!

## Medical Section:

Yes No

1. Did you ever take Tetracycline antibiotics for any period of time?

2. Do you ever have any of the following medical conditions

- 2.1 Any Genetic Diseases
- 2.2 Cerebral palsy
- 2.3 Kidney damage
- 2.4 Severe allergies
- 2.5 Cystic Fibrosis
- 2.6 Rock Mountain Spotted Fever
- 2.7 Acne

3. As a child

- 3.1 Was there any RH incompatibility when you were born?
- 3.2 Did you ever receive a head or neurological injury?
- 3.3 Did you ever take fluoride tablets?
- 3.4 Did you ever live in a high fluoride area?
- 3.5 Did you ever have a vitamin deficiency?
- 3.6 Did you ever have any blood diseases?
- 3.7 Did you ever have erythroblastosis foetalis, porphyria, haemolytic anaemia?
- 3.8 Did you ever have infant jaundice?

4. Do you smoke?

- 4.1 If yes, how many per day? ..... How long have you smoked? .....years
- 4.2 Have you ever smoked?

## Dental Section

- 1. Did you ever receive a blow to the face or teeth?
- 2. Did you ever have any accidents involving the teeth?
- 3. Have you ever bought any over the counter bleaching kits?
- 4. Are any of your teeth sensitive?
- 5. Have you been told or are you aware of any gum recession?
- 6. Do you use any mouthwashes on a regular basis?
- 7. Have you noticed that your teeth have become more yellow over the last few years?

## Diet

Yes No Amount  
per day

Do you eat any of the following?

- 1. Curry
- 2. Berries when in season
- 3. Fried Foods
- 4. Which oil do you use to fry your food?

Do you drink any of the following?

- 1. Coffee
- 2. Regular tea
- 3. Herbal Tea
- 4. Coca cola or diet coke
- 5. Red wine