Santé et Services sociaux Québec

DT9449

File number

Resident's last name

Resident's first name

Date of birth — Year Month Day — Sex ☐ M ☐ F

Health insurance number — Expiry Year Month

Area code Phone number — Area code Phone number (alt.)

ORAL HEALTH HISTORY QUESTIONNAIRE

To be filled out upon the resident's admission to a residential and long-term care centre (CHSLD)

Resident's Oral Health History

1. Do you have a dentist? ☐ Yes ☐ No

   If so, please provide their name:

2. When did you last see a dentist?

   ☐ 0-1 year ago ☐ 1-2 years ago ☐ Over 2 years ago

   Treatments received (specify):

   - Cleaning, scaling ☐ Yes ☐ No
   - Fillings ☐ Yes ☐ No
   - Root canal ☐ Yes ☐ No
   - Crown(s) or bridge(s) ☐ Yes ☐ No
   - Partial or full dentures ☐ Yes ☐ No
   - Dental extractions ☐ Yes ☐ No

3. Do you have natural teeth? ☐ Yes ☐ No

4. Please indicate whether you have:

   - A partial upper denture ☐ Yes ☐ No
   - A partial lower denture ☐ Yes ☐ No
   - A full upper denture ☐ Yes ☐ No
   - A full lower denture ☐ Yes ☐ No
   - Fixed prosthesis (crowns, bridges) ☐ Yes ☐ No
   - An implant-supported fixed denture ☐ Yes ☐ No
   - An implant-supported removable denture ☐ Yes ☐ No

5. When were your dentures made (if indicated)?

   ☐ 0-1 year ago ☐ 1-5 years ago ☐ Over 5 years ago

Resident's Oral Hygiene Habits

1. How often do you brush your teeth or dentures?

   ☐ Once a day ☐ Occasionally

   ☐ Twice a day or more ☐ I don't know

2. Please indicate whether you use:

   - A manual toothbrush ☐ Yes ☐ No
   - An electric toothbrush ☐ Yes ☐ No
   - A denture brush ☐ Yes ☐ No
   - Fluoridated toothpaste ☐ Yes ☐ No
   - Mouthwash ☐ Yes ☐ No
   - Dental floss ☐ Yes ☐ No
   - Denture cleaner (Polident©) ☐ Yes ☐ No
   - Denture adhesive (Poligrip©) ☐ Yes ☐ No

3. Do you remove your dentures at night (if indicated)? ☐ Yes ☐ No

Comments

Questionnaire filled out by:			Date
Last name and first name	Relationship to the resident	Signature	Year Month Day

Questionnaire reviewed by:			Date
Last name and first name of the nurse	Permit number	Signature	Year Month Day