



DT9449

## ORAL HEALTH HISTORY QUESTIONNAIRE

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

File number	
Resident's last name	
Resident's first name	
Date of birth	Year   Month   Day   Sex <input type="checkbox"/> M <input type="checkbox"/> F
Health insurance number	Year   Month
Area code   Phone number	Expiry   Area code   Phone number (alt.)

Resident's Oral Health History	
1. Do you have a dentist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, please provide their name:	
2. When did you last see a dentist?	<input type="checkbox"/> 0-1 year ago <input type="checkbox"/> 1-2 years ago <input type="checkbox"/> Over 2 years ago
<b>Treatments received (specify):</b>	
• Cleaning, scaling	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Root canal	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Crown(s) or bridge(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Partial or full dentures	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Dental extractions	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have natural teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Please indicate whether you have:	
• A partial upper denture	<input type="checkbox"/> Yes <input type="checkbox"/> No
• A partial lower denture	<input type="checkbox"/> Yes <input type="checkbox"/> No
• A full upper denture	<input type="checkbox"/> Yes <input type="checkbox"/> No
• A full lower denture	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Fixed prosthesis (crowns, bridges)	<input type="checkbox"/> Yes <input type="checkbox"/> No
• An implant-supported fixed denture	<input type="checkbox"/> Yes <input type="checkbox"/> No
• An implant-supported removable denture	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. When were your dentures made (if indicated)?	
	<input type="checkbox"/> 0-1 year ago <input type="checkbox"/> 1-5 years ago <input type="checkbox"/> Over 5 years ago

Resident's Oral Hygiene Habits	
1. How often do you brush your teeth or dentures?	
<input type="checkbox"/> Once a day	<input type="checkbox"/> Occasionally
<input type="checkbox"/> Twice a day or more	<input type="checkbox"/> I don't know
2. Please indicate whether you use:	
• A manual toothbrush	<input type="checkbox"/> Yes <input type="checkbox"/> No
• An electric toothbrush	<input type="checkbox"/> Yes <input type="checkbox"/> No
• A denture brush	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Fluoridated toothpaste	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Mouthwash	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Dental floss	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Denture cleaner (Polident®)	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Denture adhesive (Poligrip®)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you remove your dentures at night (if indicated)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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