

Dr. Danenberg's Questionnaire - PART A
Please answer the questions below to the best of your ability. Thank you!

Today's date:

Name:

Gender:

- Male
 Female

Age:

Weight (in lbs.):

Height (in feet and inches):

Blood Pressure (if known):

1. Current Medical Conditions (Be Specific):

2. Current Allergies (Be Specific):

3. Current Prescription Medications (Be Specific):

4. Current Supplements, Prebiotics, Probiotics, Herbs, Over-the-counter Medicines, etc. (Be Specific):

Understanding Your Mouth

5. Are you happy with your smile?

- Yes
- No

5a. If no, what is not right?

6. Have you had treatments for gum disease?

- Yes
- No

6a. If yes, what were the treatments, and were they successful?

7. Do your gums bleed?

- Yes
- No

8. Do you have swelling in your gums?

- Yes
- No

9. Are you having any pain in your mouth?

- Yes
- No

9a. If yes, please explain:

10. Do you have gum disease now?

- Yes
- No

10a. If yes, why do you think you have it?

11. Did anything change in your life when you first noticed your gum condition?

- Yes
- No
- N/A

11a. If yes, be specific:

12. Has anything made your gum problems better or worse?

- Yes
- No
- N/A

12a. If yes, be specific:

13. Do you have gum recession?

- Yes
- No

14. If yes, is it getting worse or staying the same?

15. Have your wisdom teeth been extracted?

- Yes
- No

15a. If yes, which have been extracted?

16. Have you ever had mercury (silver colored) fillings?

- Yes
- No

16a. If yes, do you still have these fillings?

- Yes
- No

17. How often do you brush your teeth?

18. How often do you floss?

19. Have you ever had dental braces?

- Yes
- No

19a. If yes, what were the results -- and/or any concerns?

20. Do you have sensitive teeth?

- Yes
- No

20a. If yes, what makes them sensitive?

21. Do you have loose teeth?

Yes

No

21a. If yes, be specific:

22. Do you have headaches in the morning?

Yes

No

23. Do you have jaw muscle soreness?

Yes

No

24. Do you have clicking or popping in your jaws?

Yes

No

25. Do you use any type of a bite guard?

Yes

No

26. Have you ever been treated for TMJ or jaw joint problems?

Yes

No

26a. If yes, be specific:

27. Are you missing any teeth?

Yes

No

27a. If yes, where are you missing teeth?

27b. If you have missing teeth, have they been replaced with artificial teeth?

Yes

No

27c. If yes, how have they been replaced?

Dr. Danenberg's Questionnaire - PART B
Please answer the questions below to the best of your ability. Thank you!

Name:

Understanding Your Body

28. If you had a magic wand and could eliminate three health/nutrition problems, what would they be?

Item #1

Item #2

Item #3

29. What part or aspect of your body bugs you the most?

30. Have you ever had a nutrition consultation?

- Yes
 No

30a. If yes, please describe:

31. What does "food" mean to you?

32. Have you made any changes in your eating habits because of your health?

- Yes
- No

32a. If yes, please describe:

33. Do you currently follow a special diet or nutritional program?

- Yes
- No

33a. If yes, please describe:

34. If you were going to change your diet, would you want to jump in and do it all at once, or would you want to take it slowly?

35. Do you avoid any particular foods?

- Yes
- No

35a. If yes, please describe:

36. How many times per week do you eat the following meals

outside your home?

Breakfast

Lunch

Dinner

37. How much time passes between each meal you eat?

38. Do you have food cravings?

Yes

No

38a. If yes, please describe:

39. If you fast, please describe:

40. What quenches your thirst during the day?

41. What are your personal challenges to eating well?

42. Do you personally go grocery shopping?

Yes

No

42a. If no, who does?

43. Do you cook?

Yes

No

43a. If no, who does?

44. Are you willing to learn new ways of cooking and buying food?

Yes

No

44a. If no, please explain:

45. What do you think would make the most positive difference in your overall health?

46. Please record the following measurements in centimeters with a tape measure:

● **Waist circumference (the smallest circumference at or above your belly button):**

● **Hip circumference (the fullest circumference around your buttocks area):**

47. In order to improve your health, how willing are you to significantly modify your diet:

Scale: 1 = "Not willing" and 5 = "Very willing"

- 1 - Not willing
- 2 - Somewhat willing
- 3 - Would consider
- 4 - Willing
- 5 - Very willing

48. In order to improve your health, how willing are you to modify your lifestyle (ex: work demands, sleep habits, meal preparation):

Scale: 1 = "Not willing" and 5 = "Very willing"

- 1 - Not willing
- 2 - Somewhat willing
- 3 - Would consider
- 4 - Willing
- 5 - Very willing

49. In order to improve your health, how willing are you to engage in regular exercise/physical activity:

Scale: 1 = "Not willing" and 5 = "Very willing"

- 1 - Not willing
- 2 - Somewhat willing
- 3 - Would consider
- 4 - Willing
- 5 - Very willing

50. In order to improve your health, how willing are you to have periodic lab tests to assess your progress:

Scale: 1 = "Not willing" and 5 = "Very willing"

- 1 - Not willing
- 2 - Somewhat willing
- 3 - Would consider
- 4 - Willing
- 5 - Very willing

51. In order to improve your health, how willing are you to keep a 3-day record when requested of everything you eat and drink:

Scale: 1 = "Not willing" and 5 = "Very willing"

- 1 - Not willing
- 2 - Somewhat willing
- 3 - Would consider
- 4 - Willing
- 5 - Very willing

52. Do you exercise?

- Yes
- No

52a. If yes, please describe.

53. Do you sleep well?

- Yes
- No

53a. If no, please explain.

54. On average, how many hours of sleep do you get per night?

55. Do you use any type of tobacco?

- Yes
- No

55a. If yes, what type tobacco, how much, and how often?

56. Do you drink alcoholic beverages?

- Yes
- No

56a. If yes, what type alcohol, how much, and how often?

57. Do you feel like you have little energy?

Yes

No

57a. If yes, please explain:

58. Do you have cold hands?

Yes

No

Dr. Danenberg's Questionnaire - PART C
Please answer the questions below to the best of your ability. Thank you!

Name:

59. Do you have cold feet?

- Yes
 No

60. How many hours a week do you spend in the sun?

60a. Of those hours in the sun, how many of them are you covered with a sunscreen product?

61. Do you have "stomach issues"?

- Yes
 No

61a. If yes, please describe:

62. Do you have generalized aches and pains?

- Yes
 No

62a. If yes, please describe: