



DIET QUESTIONNAIRE

Patient No:

Date:

- 1) How many times a day do you brush your teeth?.....
- 2) What toothpaste do you use?.....
- 3) How many meals do you have a day?.....
- 4) How many snacks/fruit do you have between meals?.....
- 5) Would you have pure fruit juice between meals? Yes/No
- 6) Do you take sugar in tea/coffee? Yes/No
If yes, how many cups a day.....
- 7) How many times a day would you drink fizzy/sports drinks?.....
- 8) Is each drink consumed all at once or sipped at over a period of time?
All at once/Sipped
- 9) Do you frequently eat mints? Yes/No
Are they sugar free? Yes/No
- 10) Do you smoke? Yes/No
How many a day?.....

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