DENTAL HISTORY

Patient Name: _____ Birthdate: _____

How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist: _____ How long have you been a patient? _____

Date of most recent dental exam: _____ Date of most recent x-rays: _____

Date of most recent treatment (other than cleaning): _____

I routinely see the dentist every: 3 months 4 months 6 months 12 months Not routinely

What is your immediate concern? _____

Please answer **YES** or **NO** to the following:

	YES	NO
Personal History		
1. Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most)?	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or have your bite adjusted?	☐	☐
6. Have you had any teeth removed?	☐	☐
Smile Characteristics		
1. Is there anything about the appearance of your teeth you would like to change?	☐	☐
2. Have you ever whitened (bleached) your teeth?	☐	☐
3. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
4. Have you been disappointed with the appearance of previous dental work?	☐	☐
Bite & Jaw Joint		
1. Do you have problems with your jaw joint? (pain, sounds, limited opening, lock popping)	☐	☐
2. Do you/would you have any problems chewing gum?	☐	☐
3. Do you/would you have any problems chewing bagels, baguettes, protien bars, or, other hard foods?	☐	☐
4. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
5. Are your teeth crowding or developing spaces?	☐	☐
6. Do you have more than one bite, or have to shift your jaw or squeeze to make your teeth fit together?	☐	☐
7. Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?	☐	☐
8. Do you clench your teeth in the daytime or do they become sore?	☐	☐
9. Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
10. Do you wear or have you ever worn a bite appliance?	☐	☐
Tooth Structure		
1. Have you had any cavities within the past 3 years?	☐	☐
2. Does the amount of saliva in your mouth seem too little or do you have any difficulty swallowing any food?	☐	☐
3. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
4. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
5. Do you have any grooves or notches on your teeth near the gum line?	☐	☐
6. Have you ever had broken teeth, chipped teeth, or had a toothache, or cracked filling?	☐	☐
7. Do you frequently get food caught between any teeth?	☐	☐
Biology		
1. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
2. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
3. Have you ever noticed an unpleasant taste/odor in your mouth?	☐	☐
4. Is there anyone with a history of periodontal disease in your family?	☐	☐
5. Have you ever noticed gum recession?	☐	☐
6. Have you ever had any teeth become loose on their own (no injury), or do you have difficulty eating an apple?	☐	☐
7. Have you experienced a burning sensation in your mouth?	☐	☐