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? ______ ☐ ☐