

# DENTAL HISTORY

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_  
Referred by \_\_\_\_\_ How would you rate the condition of your mouth?  Excellent  Good  Fair  Poor  
Previous Dentist \_\_\_\_\_ How long have you been a patient? \_\_\_\_\_ Months/Years  
Date of most recent dental exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of most recent x-rays \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of most recent treatment (other than a cleaning) \_\_\_\_/\_\_\_\_/\_\_\_\_  
I routinely see my dentist every:  3 mo.  4 mo.  6 mo.  12 mo.  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) [ \_\_\_\_ ] \_\_\_\_\_  YES  NO
2. Have you had an unfavorable dental experience? \_\_\_\_\_  YES  NO
3. Have you ever had complications from past dental treatment? \_\_\_\_\_  YES  NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_  YES  NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? \_\_\_\_\_  YES  NO
6. Have you had any teeth removed? \_\_\_\_\_  YES  NO

## GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? \_\_\_\_\_  YES  NO
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_  YES  NO
9. Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_  YES  NO
10. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_  YES  NO
11. Have you ever experienced gum recession? \_\_\_\_\_  YES  NO
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? \_\_\_\_\_  YES  NO
13. Have you experienced a burning sensation in your mouth? \_\_\_\_\_  YES  NO

## TOOTH STRUCTURE

14. Have you had any cavities within the last 3 years? \_\_\_\_\_  YES  NO
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? \_\_\_\_\_  YES  NO
16. Do you feel or notice any holes (i.e. pitting, craters) on the surface of your teeth? \_\_\_\_\_  YES  NO
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? \_\_\_\_\_  YES  NO
18. Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_  YES  NO
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_  YES  NO
20. Do you frequently get food caught between any teeth? \_\_\_\_\_  YES  NO

## BITE AND JAW JOINT

21. Do you have any problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_  YES  NO
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? \_\_\_\_\_  YES  NO
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? \_\_\_\_\_  YES  NO
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? \_\_\_\_\_  YES  NO
25. Are your teeth crowding or developing spaces? \_\_\_\_\_  YES  NO
26. Do you have more than one bite and squeeze to make your teeth fit together? \_\_\_\_\_  YES  NO
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_  YES  NO
28. Do you clench your teeth in the daytime or make them sore? \_\_\_\_\_  YES  NO
29. Do you have any problems with sleep or wake up with an awareness of your teeth? \_\_\_\_\_  YES  NO
30. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_  YES  NO

## SMILE CHARACTERISTICS

31. Is there anything about the appearance of your teeth that you would like to change? \_\_\_\_\_  YES  NO
32. Have you ever whitened (bleached) your teeth? \_\_\_\_\_  YES  NO
33. Have you felt uncomfortable or self conscious about the appearance of your teeth? \_\_\_\_\_  YES  NO
34. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_  YES  NO

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_