DENTAL HISTORY

Name________________________Preferred Name______________________ Age_______
Referred by___________________How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist______________________________How long had you been a patient? __________Months/Years
Date of most recent dental exam___/___/___Date of most recent images/x-rays___/___/___
Date of most recent treatment (other than a cleaning)___/___/___
I routinely see my dentist every: 3 month 4 month 6 month 12 month Not Routinely
What is your immediate concern?____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

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 ever 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 had your bite adjusted?_____
6. Had you had any teeth removed?_____

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing?_____
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?_____
9. Have you ever noticed an unpleasant taste or odor in your mouth?_____
10. Is there anyone with a history of periodontal disease in your family?_____
11. Have you ever experienced gum recession?_____
12. Have you ever had any teeth become loose on their own (without injury)?_____ Difficulty chewing?_____
13. Have you ever experienced a burning sensation in your mouth?_____

TOOTH STRUCTURE

14. Have you had any cavities within the past three years?_____
15. Does the amount of saliva in your mouth seem too little?_____ Difficulty swallowing any food?_____
16. Do you feel or notice any holes (i.e. pitting,craters) on the biting surface of your teeth?_____
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?____
18. Do you have grooves or notches on your teeth near the gum line?_____
19. Have you ever broken a tooth, chipped a tooth, or had a toothache or cracked filling?_____
20. Do you frequently get food caught between any of your teeth?_____

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)_____
22. Do you avoid or have difficulty chewing gum, carrots, bagels, protein bars, nuts, or other dry foods?_____
23. Have your teeth changed in the last 5 years, become shorter, thinner or worn?_____
24. Are your teeth becoming more crooked, crowded, or overlapped?_____
25. Are your teeth developing spaces or becoming loose?_____
26. Do you have to more than once bite, squeeze or shift your jaw to make your teeth fit together?_____
27. Do you place your tongue between your teeth or rest your teeth against your tongue?_____
28. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?_____
29. Do you clench your teeth?_____
30. Do you have any problems with sleep?_____Restlessness, waking up with a headache or tooth pain?____
31. Do you wear or have you ever worn a bite appliance?_____

SMILE CHARACTERISTICS

32. If you had a magic wand would you change anything about your teeth? What? (use back of page)
33. Have you ever whitened (bleached) your teeth?____
34. Have you felt uncomfortable or self-conscious about the appearance of your teeth?_____
35. Have you ever been disappointed with the appearance of previous dental work?_____

Patient Signature____ Date______
Doctor Signature____ Date_______