DENTAL HISTORY

Name: ______________________ Nickname: ______________________ Age: ________

Referred by: ______________________ 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 ____________ Dental X-rays ____________ Treatment (other than 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

	Question	Yes	No
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.	Have you ever had braces, had orthodontic treatment or had your bite adjusted?	○	○
6.	Have you had any teeth removed or are you missing teeth that never developed?	○	○

Gum and Bone

	Question	Yes	No
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 an injury), or do you have difficulty eating an apple?	○	○
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth?	○	○

Tooth Structure

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

Bite and Jaw Joint

	Question	Yes	No
21.	Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)?	○	○
22.	Do you feel like your lower jaw is being pushed back when you bite your teeth together?	○	○
23.	Do you have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	○	○
24.	Have your teeth changed in the last 5 years, become shorter, thinner, or worn?	○	○
25.	Are your teeth becoming more crooked, crowded, or overlapped?	○	○
26.	Are your teeth developing spaces or becoming more loose?	○	○
27.	Do you have to shift your jaw to make your teeth fit together?	○	○
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	○	○
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	○	○
30.	Do you clench your teeth in the daytime or make them sore?	○	○
31.	Do you have any problems with sleep (i.e. restlessness), or wake up with a headache or an awareness of your teeth?	○	○
32.	Do you wear or have you ever worn a bite appliance?	○	○

Smile Characteristics

	Question	Yes	No
33.	Is there anything about the appearance of your teeth that you would like to change?	○	○
34.	Have you ever whitened (bleached) your teeth?	○	○
35.	Have you felt uncomfortable or self-conscious about the appearance of your teeth?	○	○
36.	Have you been disappointed with the appearance of previous dental work?	○	○

Signature of Patient, Parent or Guardian: ______________________________ Date: ____________

Dr's Signature / Medical History Review: ______________________________ Date: ____________