DENTAL HISTORY

Patient 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:

PERSONAL HISTORY	○ ○ ○	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. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? ______		☐	☐
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? ______		☐	☐

GUM AND BONE	○ ○ ○	YES	NO
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? ______		☐	☐
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth? ______		☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? ______		☐	☐
10. Is there anyone with a history of periodontal disease in your family? ______		☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? ______		☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? ______		☐	☐
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth? ______		☐	☐

TOOTH STRUCTURE	○ ○ ○	YES	NO
14. Have you had any cavities within the past 3 years? ______		☐	☐
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing 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 teeth, chipped teeth, or had a toothache or cracked filling? ______		☐	☐
20. Do you frequently get food caught between any teeth? ______		☐	☐

BITE AND JAW JOINT	○ ○ ○	YES	NO
21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking? ______		☐	☐
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?		☐	☐
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ______		☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? ______		☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped? ______		☐	☐
26. Are your teeth developing spaces or becoming more loose? ______		☐	☐
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better? ______		☐	☐
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 or grind your teeth together in the daytime / nighttime or ever make them sore? ______		☐	☐
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), 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	○ ○ ○	YES	NO
33. Is there anything about the appearance of your mouth that you would like to change (color, spaces, size, shape, display)? ______		☐	☐
34. Have you ever bleached (whitened) 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? ______		☐	☐

Patient's Signature ______________________________________ Date ______________

Doctor's Signature ______________________________________ Date ______________

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