

# DENTAL HISTORY

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? Scale of 1 to 10 (very) \_\_\_\_\_  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 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

## SMILE CHARACTERISTICS ● ● ●

7. Is there anything about the appearance of your teeth that you would like to change? \_\_\_\_\_  YES  NO
8. Have you ever whitened (bleached) your teeth? \_\_\_\_\_  YES  NO
9. Are you self conscious about your teeth? \_\_\_\_\_  YES  NO
10. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_  YES  NO

## BITE AND JAW JOINT ● ● ●

11. Do you / would you have any problems chewing gum? \_\_\_\_\_  YES  NO
12. Do you / would you have any problems chewing bagels or other hard foods? \_\_\_\_\_  YES  NO
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? \_\_\_\_\_  YES  NO
14. Are your teeth crowding or developing spaces? \_\_\_\_\_  YES  NO
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? \_\_\_\_\_  YES  NO
16. Do you have any problems with sleep or wake up with an awareness of your teeth? \_\_\_\_\_  YES  NO
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_  YES  NO
18. Do you have tension headaches or sore teeth? \_\_\_\_\_  YES  NO
19. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_  YES  NO

## TOOTH STRUCTURE ● ● ●

20. Have you had any cavities within the past 3 years? \_\_\_\_\_  YES  NO
21. Do you have a dry mouth? \_\_\_\_\_  YES  NO
22. Are any teeth sensitive to hot, cold, biting or sweets? \_\_\_\_\_  YES  NO
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? \_\_\_\_\_  YES  NO
24. Do you avoid brushing any part of your mouth? \_\_\_\_\_  YES  NO
25. Do you feel or notice any holes (i.e. pitting) in your teeth? \_\_\_\_\_  YES  NO

## GUM AND BONE ● ● ●

26. Have you ever been diagnosed or treated for periodontal (gum) disease? \_\_\_\_\_  YES  NO
27. Have you ever experienced gum recession? \_\_\_\_\_  YES  NO
28. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_  YES  NO
29. Do your gums bleed when brushing, flossing or eating? \_\_\_\_\_  YES  NO
30. Are your teeth becoming loose? \_\_\_\_\_  YES  NO
31. Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_  YES  NO
32. Have you experienced a burning sensation in your mouth? \_\_\_\_\_  YES  NO

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

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