

# 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) \_\_\_\_\_
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 reactions to local anesthetic? \_\_\_\_\_
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? \_\_\_\_\_
6. Have you had any teeth removed? \_\_\_\_\_

## SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? \_\_\_\_\_
8. Have you ever whitened (bleached) your teeth? \_\_\_\_\_
9. Are you self-conscious about your teeth? \_\_\_\_\_
10. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_

## BITE AND JAW JOINT

11. Do you / would you have any problems chewing gum? \_\_\_\_\_
12. Do you / would you have any problems chewing bagels or other hard foods? \_\_\_\_\_
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? \_\_\_\_\_
14. Are your teeth crowding or developing spaces? \_\_\_\_\_
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? \_\_\_\_\_
16. Do you have any problems with sleep or wake up with an awareness of your teeth? \_\_\_\_\_
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_
18. Do you have tension headaches or sore teeth? \_\_\_\_\_
19. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_

## TOOTH STRUCTURE

20. Have you had any cavities within the past 3 years? \_\_\_\_\_
21. Do you have a dry mouth? \_\_\_\_\_
22. Are any teeth sensitive to hot, cold, biting or sweets? \_\_\_\_\_
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? \_\_\_\_\_
24. Do you avoid brushing any part of your mouth? \_\_\_\_\_
25. Do you feel or notice any holes (i.e. pitting) in your teeth? \_\_\_\_\_

## GUM AND BONE

26. Have you ever been diagnosed or treated for periodontal (gum) disease? \_\_\_\_\_
27. Have you ever experienced gum recession? \_\_\_\_\_
28. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_
29. Do your gums bleed when brushing, flossing or eating? \_\_\_\_\_
30. Are your teeth becoming loose? \_\_\_\_\_
31. Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_
32. Have you experienced a burning sensation in your mouth? \_\_\_\_\_

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

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