

# DENTAL HISTORY

Name \_\_\_\_\_ Age \_\_\_\_\_  
Recommended 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  
Why did you leave your previous Dentist \_\_\_\_\_  
Date of most recent dental exam \_\_\_\_\_  
I routinely visit the 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



- Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) \_\_\_\_\_ [ ]
- Have you had an unfavorable dental experience? \_\_\_\_\_
- Have you ever had complications from past dental treatment? \_\_\_\_\_
- Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_
- Did you ever have braces, orthodontic treatment or had your bite adjusted? \_\_\_\_\_
- Have you had any teeth removed or missing teeth that never developed? \_\_\_\_\_

## GUM AND BONE



- Do your gums bleed or are they painful when brushing or flossing? \_\_\_\_\_
- Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_
- Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_
- Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_
- Have you ever experienced gum recession? \_\_\_\_\_
- Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? \_\_\_\_\_
- Have you experienced a burning or painful sensation in your mouth not related to your teeth? \_\_\_\_\_

## TOOTH STRUCTURE



- Have you had any cavities within the past 3 years? \_\_\_\_\_
- Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? \_\_\_\_\_
- Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_
- Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? \_\_\_\_\_
- Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_
- Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_
- Do you frequently get food caught between any teeth? \_\_\_\_\_

## BITE AND JAW JOINT



- Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_
- Do you feel like your lower jaw is being pushed back when you bite your teeth together? \_\_\_\_\_
- Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? \_\_\_\_\_
- Have your teeth changed in the last 5 years, become shorter, thinner or worn? \_\_\_\_\_
- Are your teeth becoming more crooked, crowded, or overlapped? \_\_\_\_\_
- Are your teeth developing spaces or becoming more loose? \_\_\_\_\_
- Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? \_\_\_\_\_
- Do you place your tongue between your teeth or close your teeth against your tongue? \_\_\_\_\_
- Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_
- Do you clench your teeth in the daytime or make them sore? \_\_\_\_\_
- Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? \_\_\_\_\_
- Do you wear or have you ever worn a bite appliance? \_\_\_\_\_

## SMILE CHARACTERISTICS



- Is there anything about the appearance of your teeth that you would like to change? \_\_\_\_\_
- Have you ever whitened (bleached) your teeth? \_\_\_\_\_
- Have you felt uncomfortable or self conscious about the appearance of your teeth? \_\_\_\_\_
- Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_

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

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