DENTAL HISTORY

Patient Name _____ Referred by _____

How would you rate the condition of your mouth: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist_____ Phone Number (_____)_____

Most recent dental exam:_____/_____/_____ Most recent dental x-ray: _____/_____/_____

How long had you been a patient of your previous dentist : _____ Months or Years (please circle)

Most recent dental treatment (other than a cleaning) _____/_____/_____ Type of treatment:_____

I routinely see my dentist every: ☐ 3 months ☐ 6 months ☐ 1 year or longer

What is your immediate dental concern: _____

_____

Please answer Y or N to the following questions:

Personal History		
1. Are you fearful of dental treatment?	Y	N
If yes, please rate 1 (not too bad) to 10 (very) _____		
2. Have you had an unfavorable dental experience?	Y	N
3. Have you ever had complications from past dental treatment?	Y	N
4. Have you ever had trouble with local anesthetic (difficulty getting numb)?	Y	N
5. Have you ever had braces, orthodontic treatment or your bite adjusted?	Y	N
6. Have you had any teeth removed?	Y	N
Smile Characteristics		
1. Is there anything about the appearance of your teeth you would change?	Y	N
2. Have you ever whitened your teeth?	Y	N
3. Are you self-conscious about your teeth?	Y	N
4. Have you ever been disappointed with the appearance of previous dental work?	Y	N
Bite and Jaw Joint		
1. Do you have problems with your jaw joint (pain, clicks, sounds, limited opening)?	Y	N
2. Do you have problems chewing gum, carrots, bagels, protein bars or other hard foods?	Y	N
3. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	Y	N
4. Are your teeth crowding or developing spaces?	Y	N
5. Do your front teeth close with your natural bite or must you squeeze to make them fit together?	Y	N
6. Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?	Y	N
7. Do you clench your teeth in the daytime or make them sore?	Y	N
8. Do you clench or grind your teeth at night or wake up with sore teeth or jaws?	Y	N
9. Do you or have you ever worn a bite appliance?	Y	N
Tooth Structure		
1. Have you had cavities in the past 3 years?	Y	N
2. Do you frequently have dry mouth or have difficulty swallowing?	Y	N
3. Do you feel or notice and holes (i.e. pitting, craters) on the biting surface of your teeth?	Y	N
4. Are any teeth sensitive to temperature, biting, sweets, or do you avoid touching certain areas of your mouth?	Y	N
5. Do you have any grooves or notches on your teeth near the gumline?	Y	N
6. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	Y	N
7. Do you get food caught between your teeth?	Y	N
Gum and Bone		
1. Do your gums bleed when brushing, flossing or eating?	Y	N
2. Have you ever been treated for gum disease or been told you have bone loss?	Y	N
3. Have you ever noticed an unpleasant taste or odor in your mouth?	Y	N
4. Is there anyone with a history of periodontal disease in your family?	Y	N
5. Have you ever experienced gum recession?	Y	N
6. Have you ever had any teeth come loose on their own, or do you have difficulty eating an apple?	Y	N
7. Have you ever experienced a burning sensation in your mouth?	Y	N