DENTAL HISTORY

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?____

YES NO PLEASE ANSWER YES OR NO TO THE FOLLOWING :

PERSONAL HISTORY

☐ ☐ 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. Do you want to keep your remaining teeth?
☐ ☐ 5. Have you ever had trouble getting numb or had any reactions to local anesthetic?
☐ ☐ 6. Did you ever have braces, orthodontic treatment or had your bite adjusted?
☐ ☐ 7. Do you brush and floss daily? Discuss. ______________________________
☐ ☐ 8. Have you had any teeth removed?

SMILE CHARACTERISTICS

☐ ☐ 9. Is there anything about the appearance of your teeth that you would like to change?
☐ ☐ 10. Have you ever whitened (bleached) your teeth?
☐ ☐ 11. Have you felt uncomfortable or self conscious about the appearance of your teeth?
☐ ☐ 12. Have you been disappointed with the appearance of previous dental work?

BITE AND JAW JOINT

☐ ☐ 13. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)
☐ ☐ 14. Do you / would you have any problems chewing gum?
☐ ☐ 15. Do you / would you have any problems chewing bagels, baquettes, protein bars, or other hard foods?
☐ ☐ 16. Have your teeth changed in the last 5 years, become shorter, thinner or worn?
☐ ☐ 17. Are your teeth crowding or developing space?
☐ ☐ 18. Do you have more than one bite and squeeze to make your teeth fit together?
☐ ☐ 19. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?
☐ ☐ 20. Do you clench your teeth in the daytime or make them sore?
☐ ☐ 21. Do you have any problems with sleep or wake up with an awareness of your teeth?
☐ ☐ 22. Do you wear or have you ever worn a bite appliance?

TOOTH STRUCTURE

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

GUM AND BONE

☐ ☐ 30. Do your gums bleed or are they painful when brushing or flossing?
☐ ☐ 31. Have you ever been treated for gum disease or been told you have lost bone around your teeth?
☐ ☐ 32. Have you ever noticed an unpleasant taste or odor in your mouth?
☐ ☐ 33. Is there anyone with a history of periodontal disease in your family?
☐ ☐ 34. Have you ever experienced gum recession?
☐ ☐ 35. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?
☐ ☐ 36. Have you ever experienced a burning sensation in your mouth?

Patient's Signature______________________________ Date________________

Doctor's Signature ______________________________ Date________________