

DENTAL HISTORY

Patient 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? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY YES NO

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ 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 had any reactions to local anesthetic? _____ YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____ YES NO
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? _____ YES NO

GUM AND BONE YES NO

7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? _____ YES NO
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth? _____ YES NO
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? _____ YES NO
10. Is there anyone with a history of periodontal disease in your family? _____ YES NO
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____ YES NO
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? _____ YES NO
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth? _____ YES NO

TOOTH STRUCTURE YES NO

14. Have you had any cavities within the past 3 years? _____ YES NO
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food? _____ YES NO
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ YES NO
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____ YES NO
18. Do you have grooves or notches on your teeth near the gum line? _____ YES NO
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ YES NO
20. Do you frequently get food caught between any teeth? _____ YES NO

BITE AND JAW JOINT YES NO

21. Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking? _____ YES NO
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together? _____ YES NO
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ YES NO
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____ YES NO
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ YES NO
26. Are your teeth developing spaces or becoming more loose? _____ YES NO
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better? _____ YES NO
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ YES NO
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ YES NO
30. Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore? _____ YES NO
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____ YES NO
32. Do you wear or have you ever worn a bite appliance? _____ YES NO

SMILE CHARACTERISTICS YES NO

33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)? _____ YES NO
34. Have you ever bleached (whitened) your teeth? _____ YES NO
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____ YES NO
36. Have you been disappointed with the appearance of previous dental work? _____ YES NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____