DENTAL HISTORY

Patient Name ____ Nickname ___________________ Age ______

Referred by ____

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. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PERSONAL HISTORY	☐	☐	☐	**YES**	**NO**
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. Have you ever had trouble getting numb or had any reactions to local anesthetic?				☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? ____				☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?				☐	☐

GUM AND BONE	☐	☐	☐	**YES**	**NO**
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?				☐	☐
8. Have you ever had or been told you have gum disease, gum or bone loss between your teeth, or had scaling and root planing?				☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?				☐	☐
10. Is there anyone with a history of periodontal disease in your family?				☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?				☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?				☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?				☐	☐

TOOTH STRUCTURE	☐	☐	☐	**YES**	**NO**
14. Have you had any cavities within the past 3 years?				☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?				☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?				☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?				☐	☐
18. Do you have grooves or notches on your teeth near the gum line?				☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?				☐	☐
20. Do you frequently get food caught between any teeth?				☐	☐

BITE AND JAW JOINT	☐	☐	☐	YES	NO
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)				☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?				☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?				☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?				☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?				☐	☐
26. Are your teeth developing spaces or becoming more loose?				☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?				☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?				☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?				☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?				☐	☐
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?				☐	☐
32. Do you wear or have you ever worn a bite appliance?				☐	☐

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

Patient’s Signature ______________________________ Date ____________________

Doctor’s Signature ______________________________ Date ____________________