Dental History

Name:_____ Preferred Name:_____ 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): _____/____/____

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

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6mo. ☐ 12 mo. ☐ Not Routinely

What is your immediate concern:_____

		Y	N
	PERSONAL HISTORY		
1	Are you fearful of dental treatment? How fearful (Scale 1-10) (_____) _____	☐	☐
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?_____	☐	☐
6	Have you ever had any teeth removed or missing teeth that never developed?_____	☐	☐
	GUM AND BONE		
7	Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8	Have you ever been treated for gum disease or been told you have lost bone around your teeth?_____	☐	☐
9	Have you ever noticed an unpleasant odor in your mouth? _____	☐	☐
10	Is there anyone with a history of periodontal disease in your family?_____	☐	☐
11	Have you ever experienced gum recession?_____	☐	☐
12	Have you ever had any teeth become loose on their own (without 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		
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 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		
21	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)_____	☐	☐
22	Do you feel like your jaw is being pushed back when you bite your teeth together? _____	☐	☐
23	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard / dry food?_____	☐	☐
24	Have your teeth changed in the last 5 years, become shorter, thinner, or worn?_____	☐	☐
25	Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26	Are your teeth developing spaces or becoming more loose?_____	☐	☐
27	Do you have more than one bite, squeeze 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 your teeth in the daytime or make them sore?_____	☐	☐
31	Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?_____	☐	☐
32	Do you wear / have you ever worn a bite appliance? _____	☐	☐
	SMILE CHARACTERISTIC		
33	Is there anything about the appearance of your teeth you would like to change?_____	☐	☐
34	Have you ever whitened (bleached) 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:_____