DENTAL HISTORY

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 cleaning_____Date of most recent treatment_____

I routinely see my dentist every: ❑3 months ❑4 months ❑6 months ❑12 months ❑Not routinely

What is your immediate concern? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
❖ PERSONAL HISTORY ❖		
Are you fearful of dental treatment? How fearful on a scale of 1 to 10 (least to most)?_____	❑	❑
Have you had an unfavorable dental experience?	❑	❑
Have you ever have complications from past dental treatment?	❑	❑
Have you ever had trouble getting numb of have had any reactions to local anesthetic?	❑	❑
Did you ever have braces, orthodontic treatment or had your bite adjusted?	❑	❑
Have you had any teeth removed?	❑	❑
❖ SMILE CHARACTERISTICS ❖		
Is there anything about the appearance of your teeth that you would like to change?	❑	❑
Have you ever whitened (bleached) your teeth?	❑	❑
Have you ever felt uncomfortable or self-conscious about the appearance of your teeth?	❑	❑
Have you been disappointed with the appearance of previous dental work?	❑	❑
❖ BITE AND JAW JOINT ❖		
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	❑	❑
Do you/ would you have any problems chewing gum?	❑	❑
Do you/ would you have any problems chewing bagels, protein bars, baguettes or other hard foods?	❑	❑
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	❑	❑
Are your teeth crowding or developing spaces?	❑	❑
Do you consistently bite the same way?	❑	❑
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	❑	❑
Do you clench your teeth in the daytime or make them sore?	❑	❑
Do you have any problems with sleep or wake up with sore teeth?	❑	❑
Do you wear or have you ever worn a bite appliance?	❑	❑
❖ TOOTH STRUCTURE ❖		
Have you had any cavities in the last 3 years?	❑	❑
Do you feel that your mouth is dry or do you have difficulty swallowing food?	❑	❑
Do you feel or notice any holes (pitting or craters) on the chewing surface of your teeth?	❑	❑
Are any teeth sensitive to hot, cold, biting, sweets or brushing?	❑	❑
Do you have grooves or notches on your teeth near the gum line?	❑	❑
Have you ever broken or chipped teeth, or had a toothache or cracked filling?	❑	❑
Do you get food caught between any teeth?		
❖ GUM AND BONE ❖		
Do your gums bleed when brushing or flossing?	❑	❑
Have you ever been told you have lost bone around your teeth or been treated for bum disease?	❑	❑
Have you ever noticed an unpleasant taste or odor in your mouth?	❑	❑
Is there anyone with a history of periodontal disease in your family?	❑	❑
Have you ever experienced gum recession?	❑	❑
Have you ever had any teeth become loose (not due to injury) or have trouble eating an apple?	❑	❑
Have you experienced a burning sensation in your mouth?	❑	❑

Patient's signature_____Date_____

Doctor's signature_____Date_____