DENTAL HISTORY

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? Scale of 1 to 10 (very) ______	☐	☐
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 reactions to local anesthetic? ______	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ______	☐	☐
6. Have you had any teeth removed? ______	☐	☐

SMILE CHARACTERISTICS	YES	NO
7. Is there anything about the appearance of your teeth that you would like to change? ______	☐	☐
8. Have you ever whitened (bleached) your teeth? ______	☐	☐
9. Are you self conscious about your teeth? ______	☐	☐
10 Have you been disappointed with the appearance of previous dental work? ______	☐	☐

BITE AND JAW JOINT	YES	NO
11. Do you / would you have any problems chewing gum? ______	☐	☐
12. Do you / would you have any problems chewing bagels or other hard foods? ______	☐	☐
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ______	☐	☐
14. Are your teeth crowding or developing spaces? ______	☐	☐
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? ______	☐	☐
16. Do you have any problems with sleep or wake up with an awareness of your teeth? ______	☐	☐
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ______	☐	☐
18. Do you have tension headaches or sore teeth? ______	☐	☐
19. Do you wear or have you ever worn a bite appliance? ______	☐	☐

TOOTH STRUCTURE	YES	NO
20. Have you had any cavities within the past 3 years? ______	☐	☐
21. Do you have a dry mouth? ______	☐	☐
22. Are any teeth sensitive to hot, cold, biting or sweets? ______	☐	☐
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? ______	☐	☐
24. Do you avoid brushing any part of your mouth? ______	☐	☐
25. Do you feel or notice any holes (i.e. pitting) in your teeth? ______	☐	☐

GUM AND BONE	YES	NO
26. Have you ever been diagnosed or treated for periodontal (gum) disease? ______	☐	☐
27. Have you ever experienced gum recession? ______	☐	☐
28. Is there anyone with a history of periodontal disease in your family? ______	☐	☐
29. Do your gums bleed when brushing, flossing or eating? ______	☐	☐
30. Are your teeth becoming loose? ______	☐	☐
31. Have you ever noticed an unpleasant taste or odor in your mouth? ______	☐	☐
32. Have you experienced a burning sensation in your mouth? ______	☐	☐

Patient's Signature ____ Date ____________

Doctor's Signature ____ Date ____________

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