



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 (MM/DD/YYYY): ____/____/____ 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:

YES NO

Personal History

- Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)? [] _____
- Have you had an unfavorable dental experience? _____
- Have you ever had complications from past dental treatment? _____
- Have you ever had trouble getting numb or any reactions to local anesthetic? _____
- Did you ever have braces, orthodontic treatment, or had your bite adjusted? If so, at what age? _____
- Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma?

Gum and Bone

- Do your gums bleed or are they painful when brushing or flossing? _____
- Have you ever been treated for gum disease, had scaling and root planing, or been told you have lost bone around your teeth? _____
- 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 on their own (without an injury), or do you have difficulty eating an apple?
- Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____

Tooth Structure

- Have you had any cavities within the past 3 years? _____
- Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
- Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____
- Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____

Continued on next page

DENTAL HISTORY (CONT'D)

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

Tooth Structure (cont'd.)

18. Do you have any 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 lower jaw is being pushed back when you 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, 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), or 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

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 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 _____

END OF DENTAL HISTORY