

# 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 \_\_\_\_/\_\_\_\_/\_\_\_\_ 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? 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 been treated for gum disease, had scaling and root planing, or been told you have lost bone around your teeth? \_\_\_\_\_
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 \_\_\_\_\_