

# 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

- Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [\_\_\_\_] \_\_\_\_\_  YES  NO
- Have you had an unfavorable dental experience? \_\_\_\_\_  YES  NO
- Have you ever had complications from past dental treatment? \_\_\_\_\_  YES  NO
- Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_  YES  NO
- Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? \_\_\_\_\_  YES  NO
- Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? \_\_\_\_\_  YES  NO

### GUM AND BONE

YES NO

- Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? \_\_\_\_\_  YES  NO
- Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth? \_\_\_\_\_  YES  NO
- Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? \_\_\_\_\_  YES  NO
- Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_  YES  NO
- Have you ever experienced gum recession, or can you see more of the roots of your teeth? \_\_\_\_\_  YES  NO
- Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? \_\_\_\_\_  YES  NO
- Have you experienced a burning, painful sensation, or metallic taste in your mouth? \_\_\_\_\_  YES  NO

### TOOTH STRUCTURE

YES NO

- Have you had any cavities within the past 3 years? \_\_\_\_\_  YES  NO
- Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food? \_\_\_\_\_  YES  NO
- Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth? \_\_\_\_\_  YES  NO
- Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? \_\_\_\_\_  YES  NO
- Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_  YES  NO
- Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_  YES  NO
- Do you frequently get food caught between any teeth? \_\_\_\_\_  YES  NO

### BITE AND JAW JOINT

YES NO

- Does your jaw joint ever have pain, sounds (clicking, crackling, or popping), or experience limited opening or locking? \_\_\_\_\_  YES  NO
- Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together? \_\_\_\_\_  YES  NO
- Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? \_\_\_\_\_  YES  NO
- In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? \_\_\_\_\_  YES  NO
- Are your teeth becoming more crooked, crowded, or overlapped? \_\_\_\_\_  YES  NO
- Are your teeth developing spaces or becoming more loose? \_\_\_\_\_  YES  NO
- Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better? \_\_\_\_\_  YES  NO
- Do you place your tongue between your teeth or close your teeth against your tongue? \_\_\_\_\_  YES  NO
- Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_  YES  NO
- Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore? \_\_\_\_\_  YES  NO
- Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? \_\_\_\_\_  YES  NO
- Do you wear or have you ever worn a bite appliance? \_\_\_\_\_  YES  NO

### SMILE CHARACTERISTICS

YES NO

- Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)? \_\_\_\_\_  YES  NO
- Have you ever bleached (whitened) your teeth? \_\_\_\_\_  YES  NO
- Have you felt uncomfortable or self-conscious about the appearance of your teeth? \_\_\_\_\_  YES  NO
- Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_  YES  NO

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_