

# 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

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

7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? \_\_\_\_\_  
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth? \_\_\_\_\_  
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? \_\_\_\_\_  
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 feel them move when chewing? \_\_\_\_\_  
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth? \_\_\_\_\_

### TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? \_\_\_\_\_  
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing 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

21. Does your jaw joint ever have pain, sounds (clicking, crackling, or popping), or experience limited opening or locking? \_\_\_\_\_  
22. 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? \_\_\_\_\_  
23. Do you avoid or have difficulty chewing gum, raw 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 more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better? \_\_\_\_\_  
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 / nighttime or ever 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

33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, 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 \_\_\_\_\_