

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) [] _____
- Have you had an unfavorable dental experience? _____
- Have you ever had complications from past dental treatment? _____
- Have you ever had trouble getting numb or had any reactions to local anesthetic? _____
- Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____
- 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

- Do your gums bleed sometimes or are they ever painful when brushing or flossing? _____
- Have you ever been treated for gum disease 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, or can you see more of the roots of your teeth? _____
- 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



YES NO

- 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? _____
- Do you have grooves or notches on your teeth near the gum line? _____
- Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
- Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT



YES NO

- Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
- Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____
- Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
- In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____
- Are your teeth becoming more crooked, crowded, or overlapped? _____
- Are your teeth developing spaces or becoming more loose? _____
- 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? _____
- Do you place your tongue between your teeth or close your teeth against your tongue? _____
- Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
- Do you clench or grind your teeth together in the daytime or make them sore? _____
- Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____
- Do you wear or have you ever worn a bite appliance? _____

SMILE CHARACTERISTICS



YES NO

- Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)? _____
- Have you ever whitened (bleached) your teeth? _____
- Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____
- Have you been disappointed with the appearance of previous dental work? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____