

# Dental History

**Name:** \_\_\_\_\_

How would you rate the condition of your mouth?      Excellent                  Good                  Fair                  Poor

Previous Dentist: \_\_\_\_\_ How long have you been a patient? \_\_\_\_\_

Date of most recent dental exam: \_\_\_\_\_ Date of most recent x-rays: \_\_\_\_\_

Date of most recent treatment (other than cleaning): \_\_\_\_\_

I routinely see the dentist every:    3 months                  4 months                  6 months                  12 months                  Not routinely

What is your immediate concern? \_\_\_\_\_

## Please answer YES or NO to the following:

### Personal History

Y / N

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 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 have your bite adjusted? \_\_\_\_\_
6. Have you had any teeth removed? \_\_\_\_\_

### Smile Characteristics

1. Is there anything about the appearance of your teeth you would like to change? \_\_\_\_\_
2. Have you ever whitened (bleached) your teeth? \_\_\_\_\_
3. Have you felt uncomfortable or self-conscious about the appearance of your teeth? \_\_\_\_\_
4. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_

### Bite & Jaw Joint

1. Do you have problems with your jaw joint? (pain, sounds, limited opening, lock popping) \_\_\_\_\_
2. Do you/would you have any problems chewing gum? \_\_\_\_\_
3. Do you/would you have any problems chewing bagels, baguettes, protein bars, or, other hard foods? \_\_\_\_\_
4. Have your teeth changed in the last 5 years, become shorter, thinner or worn? \_\_\_\_\_
5. Are your teeth crowding or developing spaces? \_\_\_\_\_
6. Do you have more than one bite and squeeze to make your teeth fit together? \_\_\_\_\_
7. Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits? \_\_\_\_\_
8. Do you clench your teeth in the daytime or do they become sore? \_\_\_\_\_
9. Do you have any problems with sleep or wake up with an awareness of your teeth? \_\_\_\_\_
10. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_

### Tooth Structure

1. Have you had any cavities within the past 3 years? \_\_\_\_\_
2. Does the amount of saliva in your mouth seem too little or do you have any difficulty swallowing any food? \_\_\_\_\_
3. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_
4. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? \_\_\_\_\_
5. Do you have any grooves or notches on your teeth near the gum line? \_\_\_\_\_
6. Have you ever had broken teeth, chipped teeth, or had a toothache, or cracked filling? \_\_\_\_\_
7. Do you frequently get food caught between any teeth? \_\_\_\_\_

### Biology

1. Do your gums bleed or are they painful when brushing or flossing? \_\_\_\_\_
2. Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_
3. Have you ever noticed an unpleasant odor in your mouth? \_\_\_\_\_
4. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_
5. Have you ever noticed gum recession? \_\_\_\_\_
6. Have you ever had any teeth become loose on their own (no injury), or do you have difficulty eating an apple? \_\_\_\_\_
7. Have you experienced a burning sensation in your mouth? \_\_\_\_\_