# Dental History

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-ray_____/_____/_____

Date of most recent treatment (other than cleaning) _____/_____/_____

I routinely see my 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 | YES | NO |
|---|---|---|
| 1) Are you fearful of dental treatment? How fearful, on a scale of 1(least) to 10(most)__________________________ | o | o |
| 2) Have you ever had an unfavorable dental experience? ____________________________________________ | o | o |
| 3) Have you ever had complications from past dental treatment? _______________________________________ | o | o |
| 4) Have you ever had trouble getting numb or had any reactions to local anesthetic? ______________________ | o | o |
| 5) Did you ever had braces, orthodontic treatment or had your bite adjusted? _____________________________ | o | o |
| 6) Have you had any teeth removed or missing teeth that never developed? ______________________________ | o | o |
| **GUM AND BONE** | | |
| 1) Do your gums bleed or are they painful when brushing and/or flossing? _______________________________ | o | o |
| 2) Have you ever been treated for gum disease or been told you have lost bone around your teeth? ___________ | o | o |
| 3) Have you ever noticed an unpleasant taste or odor in your mouth? __________________________________ | o | o |
| 4) Is there anyone with a history of periodontal disease in your family?________________________________ | o | o |
| 5) Have you ever experienced gum recession? ___________________________________________________ | o | o |
| 6) Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ______________________________________________________________ | o | o |
| | o | o |
| 7) Have you experienced a burning or painful sensation in your mouth not related to your teeth? ____________ | o | o |
| **TOOTH STRUCTURE** | | |
| 1) Have you had any cavities within the past 3 years?_____________________________________________ | o | o |
| 2) Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ | o | o |
| 3) Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _______________ | o | o |
| 4) Are any teeth sensitive to hot, cold, biting, sweets or avoid brushing any parts of your mouth? ___________ | o | o |
| 5) Do you have a grooves or notches on your teeth near the gum line? _________________________________ | o | o |
| 6) Have you ever broken teeth, chipped teeth or had a toothache or cracked filling? | o | o |
| 7) Do you frequently get food caught between any teeth? | o | o |
| **BITE AND JAW JOINT** | | |
| 1) Do you have problems with your jaw joint?(pain, sounds, limited opening, locking popping?_______________ | o | o |
| 2) Do you feel like your lower jaw is being pushed back when you bite your teeth together? ________________ | o | o |
| 3) Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or any other hard dry foods?_____________________________________________________________ | o | o |
| | o | o |
| 4) Have you changed in the last 5 years, become shorter, thinner or worn? _____________________________ | o | o |
| 5) Are your teeth becoming more crooked, crowded or overlapping? ____________________________________ | o | o |
| 6) Are your teeth developing spaces or becoming more loose? ________________________________________ | o | o |
| 7) Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____________ | o | o |
| 8) Do you place your tongue between your teeth or close your teeth against your tongue? _________________ | o | o |
| 9) Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ___________ | o | o |
| 10) Do you clench your teeth in the daytime or make them sore?_____________________________________ | o | o |
| 11) Do you have any problems sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? | o | o |
| 12) Do you wear or have you ever worn a bite appliance? ___________________________________________ | o | o |
| | o | o |
| **SMILE CHARACTERISTICS** | | |
| 1) Is there anything about the appearance of your teeth that you would like to change? ___________________ | o | o |
| 2) Have you ever tried whitening (bleached) your teeth? ____________________________________________ | o | o |
| 3) Have you ever felt uncomfortable or self-conscious about the appearance of your teeth? ________________ | o | o |
| 4) Have you been disappointed with the appearance of previous dental work?_____________________________ | o | o |

Patient's Signature ____________________________________________________ Date _________________

Doctor's Signature ____________________________________________________ Date _________________