

# 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

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

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YES NO

7. Do your gums bleed sometimes or are they ever painful when brushing or flossing? \_\_\_\_\_ ☐ ☐
8. Have you ever been treated for gum disease, had scaling and root planing, or been told you have lost bone around your teeth? \_\_\_\_\_ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_ ☐ ☐
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 do you have difficulty eating an apple? \_\_\_\_\_ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? \_\_\_\_\_ ☐ ☐

### TOOTH STRUCTURE

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YES NO

14. Have you had any cavities within the past 3 years? \_\_\_\_\_ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing 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

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YES NO

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? \_\_\_\_\_ ☐ ☐
23. Do you avoid or have difficulty chewing gum, 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 trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? \_\_\_\_\_ ☐ ☐
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 or 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

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YES NO

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