DENTAL HISTORY

Patient Name_____

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

Previous Dentist _____ How long had you been a patient? _____

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 months ☐ 6 months ☐ 12 months ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PERSONAL HISTORY	Yes	No
Are you fearful of dental treatment? Scale of 1 to 10 (very)	☐	☐
Have you had an unfavorable dental experience?	☐	☐
Have you ever had complications from past dental treatment?	☐	☐
Have you ever had trouble getting numb or reactions to local anesthetic?	☐	☐
Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
Have you had any teeth removed?	☐	☐

SMILE CHARACTERISTICS		
Is there anything about the appearance of your teeth that you would like to change?	☐	☐
Have you ever whitened (bleached) your teeth?	☐	☐
Are you self conscious about your teeth?	☐	☐
Have you been disappointed with the appearance of previous dental work?	☐	☐

BITE AND JAW JOINT		
Do you/ would you have any problems chewing gum?	☐	☐
Do you/ would you have any problems chewing bagels or other hard foods?	☐	☐
Have your teeth changed in the last 5 years, become shorter, thinner, worn?	☐	☐
Are your teeth crowding or developing spaces?	☐	☐
Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	☐	☐
Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
Do you have tension headaches or sore teeth?	☐	☐
Do you wear or have you ever worn a bite appliance?	☐	☐

TOOTH STRUCTURE		
Have you had any cavities within the past 3 years?	☐	☐
Do you have a dry mouth?	☐	☐
Are any teeth sensitive to hot, cold, biting or sweets?	☐	☐
Have you ever had a toothache, cracked filling, or broken, chipped or cracked tooth?	☐	☐
Do you avoid brushing any part of your mouth?	☐	☐
Do you feel or notice any holes (i.e. pitting) in your teeth?	☐	☐

GUM AND BONE		
Have you ever been diagnosed or treated for periodontal (gum) disease?	☐	☐
Have you ever experienced gum recession?	☐	☐
Is there anyone with a history of periodontal disease in your family?	☐	☐
Do your gums bleed when brushing, flossing or eating?	☐	☐
Are your teeth becoming loose?	☐	☐
Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
Have you experienced a burning sensation in your mouth?	☐	☐

Signature _____ Date _____

Relationship to patient _____