

# 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-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:

YES NO

## PERSONAL HISTORY



- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment? _____                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____              | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed or missing teeth that never developed? _____                         | <input type="checkbox"/> | <input type="checkbox"/> |

## GUM AND BONE



- |   |                          |                          |
|---|--------------------------|--------------------------|
| 7. Do your gums bleed or are they painful when brushing or flossing? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever noticed an unpleasant taste or odor in your mouth? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is there anyone with a history of periodontal disease in your family? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever experienced gum recession? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____                          | <input type="checkbox"/> | <input type="checkbox"/> |

## TOOTH STRUCTURE



- |  |                          |                          |
|--|--------------------------|--------------------------|
| 14. Have you had any cavities within the past 3 years? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____           | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____        | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have grooves or notches on your teeth near the gum line? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you frequently get food caught between any teeth? _____   | <input type="checkbox"/> | <input type="checkbox"/> |

## BITE AND JAW JOINT



- |  |                          |                          |
|--|--------------------------|--------------------------|
| 21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are your teeth becoming more crooked, crowded, or overlapped? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are your teeth developing spaces or becoming more loose? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you place your tongue between your teeth or close your teeth against your tongue? _____                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you clench your teeth in the daytime or make them sore? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____        | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Do you wear or have you ever worn a bite appliance? _____  | <input type="checkbox"/> | <input type="checkbox"/> |

## SMILE CHARACTERISTICS



- |   |                          |                          |
|---|--------------------------|--------------------------|
| 33. Is there anything about the appearance of your teeth that you would like to change? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you ever whitened (bleached) your teeth? _____                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you been disappointed with the appearance of previous dental work? _____             | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_