

# DENTAL HISTORY

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? Scale of 1 to 10 (very) \_\_\_\_\_
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 reactions to local anesthetic?.....
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?.....
6. Have you had any teeth removed?.....

**Smile Characteristics**

7. Is there anything about the appearance of your teeth that you would like to change?.....
8. Have you ever whitened (bleached) your teeth?.....
9. Are you self conscious about your teeth?.....
10. Have you been disappointed with the appearance of previous dental work?.....

**Bite and Jaw Joint**

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

**Tooth Structure**

20. Have you had any cavities within the past 3 years?.....
21. Do you have a dry mouth?.....
22. Are any teeth sensitive to hot, cold, biting or sweets?.....
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?.....
24. Do you avoid brushing any part of your mouth?.....

**Gum and Bone**

25. Have you ever been diagnosed or treated for periodontal (gum) disease?.....
26. Have you ever experienced gum recession?.....
27. Is there anyone with a history of periodontal disease in your family?.....
28. Do your gums bleed when brushing, flossing or eating?.....
29. Are your teeth becoming loose?.....
30. Have you ever noticed an unpleasant taste or odor in your mouth?.....
31. Have you experienced a burning sensation in your mouth?.....

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

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