

# 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) [ ] _____                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment? _____  | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### GUM AND BONE

- |   |                          | YES                      | NO                       |
|---|--------------------------|--------------------------|--------------------------|
| 7. Do your gums bleed sometimes or are they ever painful when brushing or flossing? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had or been told you have gum disease, gum or bone loss between your teeth, or had scaling and root planing? _____ | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| 10. Is there anyone with a history of periodontal disease in your family? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____                                  | <input type="checkbox"/> | <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"/> | <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"/> | <input type="checkbox"/> |

### TOOTH STRUCTURE

- |  |                          | YES                      | NO                       |
|--|--------------------------|--------------------------|--------------------------|
| 14. Have you had any cavities within the past 3 years? _____   | <input type="checkbox"/> | <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"/> | <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"/> | <input type="checkbox"/> |
| 17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____ | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| 19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you frequently get food caught between any teeth? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### BITE AND JAW JOINT

- |  |                          | YES                      | NO                       |
|--|--------------------------|--------------------------|--------------------------|
| 21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____                                    | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| 24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are your teeth becoming more crooked, crowded, or overlapped? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are your teeth developing spaces or becoming more loose? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? _____ | <input type="checkbox"/> | <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"/> | <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"/> | <input type="checkbox"/> |
| 30. Do you clench or grind your teeth together in the daytime or make them sore? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? _____      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Do you wear or have you ever worn a bite appliance? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### SMILE CHARACTERISTICS

- |  |                          | 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)? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you ever bleached (whitened) your teeth? _____  | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| 36. Have you been disappointed with the appearance of previous dental work? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

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