DENTAL HISTORY

Date _____

Full Name _____ Date of Birth _____

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

Previous Dentist _____ How long were you a patient? _____

Date of Most Recent: Exam _____ X-Rays _____ Treatment _____

What is your immediate concern? _____

On a scale of 1 (least) to 10 (most), how fearful are you of dental treatment? 1 2 3 4 5 6 7 8 9 10

Please check yes or no to the following questions

Yes	No	
____	____	Have you ever had an unfavorable dental experience?
____	____	Have you ever had complications from past dental treatments?
____	____	Have you ever had trouble getting numb, or had any 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 you would like to change?
____	____	Have you ever whitened (bleached) your teeth?
____	____	Have you been disappointed with the appearance of your previous dental work?

Bite and Jaw

____	____	Do you have problems with your jaw joint, i.e. pain, sounds, limited opening, locking, etc.?
____	____	Have your teeth changed in the last 5 years, become shorter, thinner, or worn?
____	____	Are your teeth crowding or developing space?
____	____	Do you clench your teeth in the daytime or make them sore?
____	____	Do you have any problems with sleep, or wake up with an awareness of your teeth?
____	____	Do you wear, or have you ever worn, a bite appliance?

Tooth Structure

____	____	Have you had cavities within the last 3 years?
____	____	Do you seem to have too little saliva, or have difficulty swallowing food?
____	____	Do you feel or notice any holes (i.e. pitting, craters) on the biting surfaces of your teeth?
____	____	Are any teeth sensitive to hot, cold, biting, or sweets?
____	____	Do you avoid brushing any part of your mouth?
____	____	Do you have grooves or notches on your teeth near the gumline?
____	____	Have you ever broken teeth, chipped teeth, or had a toothache and cracked filling?
____	____	Do you frequently get food caught between any teeth?

Gum and Bone

____	____	Do your gums bleed, or are they painful while brushing or flossing?
____	____	Have you ever been treated for gum disease, or been told you have lost bone around your teeth?
____	____	Have you ever noticed an unpleasant taste or odor in your mouth?
____	____	Has anyone in your family had a history of periodontal disease?
____	____	Have you ever experienced gum recession?
____	____	Have you ever had any teeth come loose on their own (without an injury)?
____	____	Have you experienced a burning sensation in your mouth?