

# 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

- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? _____                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## SMILE CHARACTERISTICS

- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Is there anything about the appearance of your teeth that you would like to change? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever whitened (bleached) your teeth? _____                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you been disappointed with the appearance of previous dental work? _____            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## BITE AND JAW JOINT

- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you / would you have any problems chewing gum? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are your teeth crowding or developing spaces? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have more than one bite and squeeze to make your teeth fit together? _____                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. 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"/> |
| 18. Do you clench your teeth in the daytime or make them sore? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you wear or have you ever worn a bite appliance? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## TOOTH STRUCTURE

- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you had any cavities within the past 3 years? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. 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"/> |
| 23. 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"/> |
| 24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you have grooves or notches on your teeth near the gum line? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you get food caught between any teeth? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## GUM AND BONE

- |   |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|
|   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do your gums bleed when brushing or flossing? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you ever noticed an unpleasant taste or odor in your mouth? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Is there anyone with a history of periodontal disease in your family? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you ever experienced gum recession? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. 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"/> |
| 34. Have you experienced a burning sensation in your mouth? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

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