Dental History

Date: ________ Patient Name: ______________________________ Age: __________

Date of birth: ________________

Referred by: ______________________________________

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

Previous DDS: ___________________________ How long were you a patient? _____________

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? ____

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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 (lowest) to 10 (most)? ______ ◯ ◯
2. Have you had an unfavorable dental experience? _____________________________ ◯ ◯
3. Have you ever had complications from past dental treatments? __________________ ◯ ◯
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ____ ◯ ◯

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5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _________ ◯ ◯
6. Have you had any teeth removed or missing teeth that never developed? ___________ ◯ ◯

Gum and Bone

7. Do your gums bleed or are they painful with flossing? __________________________ ◯ ◯
8. Have you ever been treated for gum disease or have been told you have lost bone around your teeth? ____ ◯ ◯
9. Have you ever noticed an unpleasant odor or taste in your mouth? _______________ ◯ ◯
10. Is there anyone with a history of periodontal disease in your family? _____________ ◯ ◯
11. Have you ever experienced gum recession? ________________________________ ◯ ◯
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ____ ◯ ◯
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ____ ◯ ◯

Tooth Structure

14. Have you had any cavities in the past 3 years? ______________________________ ◯ ◯
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ____ ◯ ◯

Tooth Structure, continued

16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth ◯ ◯
17. Are there any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ____ ◯ ◯
18. Do you have any grooves or notches on your teeth near the gumline? _____________ ◯ ◯
19. Have you ever broken or chipped teeth, had a toothache or cracked a filling? ________ ◯ ◯
20. Do you frequently get food stuck between any teeth? _________________________ ◯ ◯

Bite and Jaw Joint

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

Smile Characteristics

33. Is there anything about the appearance of your teeth that you would like to change? ◯ ◯

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34. Have you ever whitened (bleached) your teeth? ______________________________ ◯ ◯
35. Have you ever felt uncomfortable of self conscious about the appearance of your teeth? ____ ◯ ◯
36. Have you ever been disappointed with the appearance of previous dental work? ____ ◯ ◯

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Patient's Signature: ___________________________________ Date: _______________

Doctor's Signature: ___________________________________ Date: _______________