

DENTAL HISTORY

How would you rate the condition of your mouth? **Circle one:** 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: Circle one: 3 mo. 4mo. 6mo. 12 mo. Not Routinely

What is your immediate concern? _____

PERSONAL HISTORY (PLEASE CIRCLE YES OR NO TO THE FOLLOWING)

- | | | |
|---|-----|----|
| 1. Are you fearful of dental treatment? Scale of 1-10 (very)..... | Yes | No |
| 2. Have you had an unfavorable dental experience? | Yes | No |
| 3. Have you ever had complications from past dental treatment? | Yes | No |
| 4. Have you ever had trouble getting numb or reactions from anesthetic? | Yes | No |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted? | Yes | No |
| 6. Have you ever had teeth removed? | Yes | No |

SMILE CHARACTERISTICS

- | | | |
|--|-----|----|
| 7. Is there anything about the appearance of your teeth that you would like to change? | Yes | No |
| 8. Have you ever whitened (bleached) your teeth? | Yes | No |
| 9. Are you self conscious about your teeth? | Yes | No |
| 10. Have you been disappointed with the appearance of previous dental work? | Yes | No |

BITE AND JAW JOINT

- | | | |
|--|-----|----|
| 11. Do you / would you have any problems chewing gum? | Yes | No |
| 12. Do you / would you have any problems chewing bagels or other hard foods? | Yes | No |
| 13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? | Yes | No |
| 14. Are your teeth crowding or developing spaces? | Yes | No |
| 15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? | Yes | No |
| 16. Do you have any problems with sleep or wakeup with an awareness of your teeth? | Yes | No |
| 17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)? | Yes | No |
| 18. Do you have tension headaches or sore teeth? | Yes | No |
| 19. Do you wear or have you ever worn a bite appliance? | Yes | No |

TOOTH STRUCTURE

- | | | |
|---|-----|----|
| 20. Have you had any cavities within the past 3 years? | Yes | No |
| 21. Do you have dry mouth? | Yes | No |
| 22. Are any teeth sensitive to hot, cold, biting or sweets? | Yes | No |
| 23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? | Yes | No |
| 24. Do you avoid brushing any part of your mouth? | Yes | No |
| 25. Do you feel or notice any holes (i.e. pitting) in your teeth? | Yes | No |

GUM AND BONE

- | | | |
|--|-----|----|
| 26. Have you ever been diagnosed or treated for periodontal (gum) disease? | Yes | No |
| 27. Have you ever experienced gum recession? | Yes | No |
| 28. Is there anyone with a history of periodontal disease in your family? | Yes | No |
| 29. Do your gums bleed when brushing, flossing or eating? | Yes | No |
| 30. Are your teeth becoming loose? | Yes | No |
| 31. Have you ever noticed an unpleasant taste or odor in your mouth?..... | Yes | No |
| 32. Have you experienced a burning sensation in your mouth? | Yes | No |

Patient's Signature _____ Date _____

Doctor's/Assistant's Signature _____ Date _____