

# 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="radio"/>    | <input type="radio"/>    | <input type="radio"/>    |
| 1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____               | <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 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="radio"/>    | <input type="radio"/>    | <input type="radio"/>    |
| 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. Are you self conscious about 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="radio"/>    | <input type="radio"/>    | <input type="radio"/>    |
| 11. Do you / would you have any problems chewing gum? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you / would you have any problems chewing bagels or other hard foods? _____                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are your teeth crowding or developing spaces? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. 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"/> |
| 17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have tension headaches or sore teeth? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you wear or have you ever worn a bite appliance? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## TOOTH STRUCTURE

- |   |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|
|   | <input type="radio"/>    | <input type="radio"/>    | <input type="radio"/>    |
| 20. Have you had any cavities within the past 3 years? _____                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have a dry mouth? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Are any teeth sensitive to hot, cold, biting or sweets? _____                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you avoid brushing any part of your mouth? _____                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you feel or notice any holes (i.e. pitting) in your teeth? _____                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## GUM AND BONE

- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
|  | <input type="radio"/>    | <input type="radio"/>    | <input type="radio"/>    |
| 26. Have you ever been diagnosed or treated for periodontal (gum) disease? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you ever experienced gum recession? _____                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Is there anyone with a history of periodontal disease in your family? _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do your gums bleed when brushing, flossing or eating? _____                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Are your teeth becoming loose? _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever noticed an unpleasant taste or odor in your mouth? _____       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. 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 \_\_\_\_\_