

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

- | | | |
|--|--------------------------|--------------------------|
| 1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment?..... | <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"/> |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Smile Characteristics

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

Bite and Jaw Joint

- | | | |
|--|--------------------------|--------------------------|
| 11. Do you / would you have any problems chewing gum? | <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"/> |
| 13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are your teeth crowding or developing spaces?..... | <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"/> |
| 16. Do you have any problems with sleep or wake up with an awareness of your teeth?..... | <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"/> |
| 18. Do you have tension headaches or sore teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you wear or have you ever worn a bite appliance?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Tooth Structure

- | | | |
|--|--------------------------|--------------------------|
| 20. Have you had any cavities within the past 3 years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have a dry mouth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Are any teeth sensitive to hot, cold, biting or sweets?..... | <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"/> |
| 24. Do you avoid brushing any part of your mouth?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Gum and Bone

- | | | |
|---|--------------------------|--------------------------|
| 25. Have you ever been diagnosed or treated for periodontal (gum) disease?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever experienced gum recession?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Is there anyone with a history of periodontal disease in your family?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do your gums bleed when brushing, flossing or eating?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Are your teeth becoming loose?..... | <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"/> |
| 31. Have you experienced a burning sensation in your mouth?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____