Dental History

Last Name: _____First Name: _____ Birthdate: _____

Referred by: _____

Previous Dentist: _____Date of recent Dental Exam: _____

Date of recent X-rays: _____Date of recent treatment (other than cleaning): _____

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

Personal History:

	Y	N	DK
Are you fearful of dental treatment?			
Have you had an unfavorable dental experience?			
Have you ever had complications from past dental treatment?			
Have you ever had trouble getting numb or had any reactions to local anesthetic?			
Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?			
Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?			

Gum & Bone

	Y	N	DK
Do your gums bleed sometimes or are they ever painful when brushing or flossing?			
Have you been treated for gum disease, had scaling and root planning, or been told you have lost bone around your teeth?			
Have you ever noticed an unpleasant taste or odor in your mouth?			
Is there anyone with a history of periodontal disease in your family?			
Have you ever experienced gum recession, or can you see more of the roots of your teeth?			
Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?			
Have you ever experienced a burning or painful sensation in your mouth not related to your teeth?			

Tooth Structure

	Y	N	DK
Have you had any cavities within the past 3 years?			
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?			
Do you feel or notice any holes(i.e. pitting, craters) on the biting surface of your teeth?			
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?			
Do you have grooves or notches on your teeth near the gum line?			
Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?			
Do you frequently get food caught between any teeth?			

Bite & Jaw Joint

	Y	N	DK
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)			
Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?			
Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?			
In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?			
Are your teeth becoming more crooked, crowded, or overlapped?			
Are your teeth developing spaces or becoming looser?			
Do you have trouble finding your bite, or need to squeeze, shift your jaw to make your teeth fit or tap your teeth together?			
Do you place your tongue between your teeth or close your teeth against your tongue?			
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?			
Do you clench or grind your teeth together in the daytime or make them sore?			
Do you have any problems with sleep (teeth grinding), wake up with a headache or an awareness of your teeth?			
Do you wear or have you ever worn a bite appliance?			

Smile Characteristics

	Y	N	DK
Is there anything about the appearance of your mouth(smile, lips, teeth) that you would like to change(shape, color, size)?			
Have you ever bleached (whitened) your teeth?			
Have you felt uncomfortable or self-conscious about the appearance of your teeth?			
Have you been disappointed with the appearance of previous dental work?			

Patient Signature Date: