

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____
 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:

PERSONAL HISTORY

- | | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | YES | NO |
|---|-----------------------|-----------------------|-----------------------|--------------------------|--------------------------|
| 1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ | | | | <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 had any reactions to local anesthetic? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |

GUM AND BONE

- | | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | YES | NO |
|---|-----------------------|-----------------------|-----------------------|--------------------------|--------------------------|
| 7. Do your gums bleed sometimes or are they ever painful when brushing or flossing? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been treated for gum disease, had scaling and root planing, or been told you have lost bone around your teeth? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is there anyone with a history of periodontal disease in your family? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |

TOOTH STRUCTURE

- | | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | YES | NO |
|--|-----------------------|-----------------------|-----------------------|--------------------------|--------------------------|
| 14. Have you had any cavities within the past 3 years? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have grooves or notches on your teeth near the gum line? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you frequently get food caught between any teeth? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |

BITE AND JAW JOINT

- | | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | YES | NO |
|--|-----------------------|-----------------------|-----------------------|--------------------------|--------------------------|
| 21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are your teeth becoming more crooked, crowded, or overlapped? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are your teeth developing spaces or becoming more loose? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you clench or grind your teeth together in the daytime or make them sore? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Do you wear or have you ever worn a bite appliance? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |

SMILE CHARACTERISTICS

- | | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | YES | NO |
|--|-----------------------|-----------------------|-----------------------|--------------------------|--------------------------|
| 33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you ever bleached (whitened) your teeth? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you been disappointed with the appearance of previous dental work? _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

