DENTAL HISTORY

FIRST NAME: _____ LAST NAME: _____

NICKNAME: _____ AGE: _____

REFERRED BY: _____

HOW WOULD YOU RATE THE CONDITION OF YOUR MOUTH?

EXCELLENT GOOD FAIR POOR

NAME OF YOUR PREVIOUS DENTIST(S): _____

HOW LONG HAVE YOU BEEN A PATIENT? MONTHS OR 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 DENTISTS EVERY:

3 MONTHS 4 MONTHS 6 MONTHS 12 MONTHS

NOT ROUTINELY

WHAT IS YOUR IMMEDIATE CONCERN?

_____

_____

PERSONAL HISTORY

1.) ARE YOU FEARFUL OF DENTAL TREATMENT ?
YES NO
SCALE OF 1-10 : _____

2.) HAVE YOU HAD AN UNFAVORABLE DENTAL EXPERIENCE?
YES NO

3.) HAVE YOU EVER HAD COMPLICATIONS FROM YOUR PAST DENTAL TREATMENT?
YES NO

4.) HAVE YOU EVER HAD TROUBLE GETTING NUMB OR HAD ANY REACTIONS TO LOCAL ANESTHETIC?
YES NO

5.) DID YOU EVER HAVE BRACES, ORTHODONTIC TREATMENT OR HAD YOUR BITE ADJUSTED?
YES NO

6.) HAVE YOU HAD ANY TEETH REMOVED?
YES NO

7.) DO YOUR GUMS BLEED OR ARE THEY PAINFUL WHEN BRUSHING OR FLOSSING?
YES NO

8.) HAVE YOU EVER BEEN TREATED FOR GUM DISEASE OR BEEN TOLD YOU HAVE LOST BONE AROUND YOUR TEETH?
YES NO

9.) HAVE YOU EVER NOTICED AN UNPLEASANT TASTE OR ODOR IN YOUR MOUTH?
YES NO

10.) IS THERE ANYONE WITH A HISTORY OF PERIODONTAL DISEASE IN YOUR FAMILY?
YES NO

11.) HAVE YOU EVER EXPERIENCED GUM RECESSION?
YES NO

12.) HAVE YOU EVER HAD ANY TEETH BECOME LOOSE ON THEIR OWN (WITHOUT AN INJURY), OR DO YOU HAVE DIFFICULTY EATING AN APPLE?
YES NO

13.) HAVE YOU EXPERIENCED A BURNING SENSATION IN YOUR MOUTH?
YES NO

14.) HAVE YOU HAD ANY CAVITIES WITHIN THE PAST 3 YEARS?
YES NO

15.) DOES THE AMOUNT OF SALIVA IN YOUR MOUTH SEEM TOO LITTLE OR DO YOU HAVE DIFFICULTY SWALLOWING ANY FOOD?
YES NO

16.) DO YOU FEEL OR NOTICE ANY HOLES (I.E. PITTING, CRATERS) ON THE BITING SURFACES OF YOUR TEETH?
YES NO

17.) ARE ANY TEETH SENSITIVE TO HOT, COLD, BITING, SWEETS, OR AVOID BRUSHING ANY PART OF YOUR MOUTH?
YES NO

18.) DO YOU HAVE ANY GROOVES OR NOTCHES ON YOUR TEETH NEAR THE GUM LINE?
YES NO

19.) HAVE YOU EVER BROKEN TEETH, CHIPPED TEETH, OR HAD A TOOTHACHE OR CRACKED FILLING?
YES NO

20.) DO YOU FREQUENTLY GET FOOD CAUGHT BETWEEN ANY TEETH?
YES NO

BITE & JAW JOINT

21.) DO YOU HAVE PROBLEMS WITH YOUR JAW JOINT? (PAIN, SOUNDS, LIMITED OPENING, LOCKING, POPPING)?
YES NO

22.) DO YOU FEEL LIKE YOUR LOWER JAW IS BEING PUSHED BACK WHEN YOU BITE YOUR TEETH TOGETHER?
YES NO

23.) DO YOU AVOID OR HAVE DIFFICULTY CHEWING GUM, CARROTS, NUTS, BAGELS, BAGUETTES, PROTEIN BARS, OR OTHER HARD , DRY FOODS?
YES NO

24.) HAVE YOUR TEETH CHANGED IN THE LAST 5 YEARS, BECOME SHORTER , THINNER OR WORN?
YES NO

25.) ARE YOUR TEETH BECOMING MORE CROOKED, CROWDED , OR OVERLAPPED?
YES NO

26.) ARE YOUR TEETH DEVELOPING SPACES OR BECOMING MORE LOOSE?
YES NO

27.) DO YOU HAVE MORE THAN ONE BITE, SQUEEZE, OR SHIFT YOUR JAW TO MAKE YOUR TEETH FIT TOGETHER?

YES NO

28.) DO YOU PLACE YOUR TONGUE BETWEEN YOUR TEETH OR REST YOUR TEETH AGAINST YOUR TONGUE?

YES NO

29.) DO YOU CHEW ICE, BITE YOUR NAILS, USE YOUR TEETH TO HOLD OBJECTS, OR HAVE ANY OTHER ORAL HABITS?

YES NO

30.) DO YOU CLENCH YOUR TEETH IN THE DAYTIME OR MAKE THEM SORE?

YES NO

31.) DO YOU HAVE ANY PROBLEMS WITH SLEEP (I.E. RESTLESSNESS), WAKE UP WITH A HEADACHE OR AN AWARENESS OF YOUR TEETH?

YES NO

32.) DO YOU WEAR OR HAVE YOU EVER WORN A BITE APPLIANCE?

YES NO

SMILE CHARACTERISTICS

33.) IS THERE ANYTHING ABOUT THE APPEARANCE OF YOUR TEETH THAT YOU WOULD CHANGE?

YES NO

34.) HAVE YOU EVER WHITENED (BLEACHED) YOUR TEETH?

YES NO

35.) HAVE YOU FELT UNCOMFORTABLE OR SELF CONSCIOUS ABOUT THE APPEARANCE OF YOUR TEETH?

YES NO

36.) HAVE YOU BEEN DISAPPOINTED WITH THE APPEARANCE OF PREVIOUS DENTAL WORK?

YES NO

_____ _____

SIGNATURE DATE