

## DENTAL HISTORY

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ DOB \_\_\_\_\_

On a scale of 1 to 10 (with 10 being completely healthy), where do you rate your current level of oral health? \_\_\_\_\_

Previous Dentist \_\_\_\_\_ How long have you been a patient there? \_\_\_\_\_ 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 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

My main dental concern is \_\_\_\_\_

	Yes	No
<b>PERSONAL HISTORY</b>		
1. Are you fearful of dental treatment? If so, 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?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any teeth removed?	<input type="checkbox"/>	<input type="checkbox"/>
<b>GUM AND BONE</b>		
7. Do your gums bleed or are they painful when brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been treated for gum disease 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?	<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 sensation in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
<b>TOOTH STRUCTURE</b>		
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 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"/>
<b>BITE AND JAW JOINT</b>		
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 bite your 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. Have you teeth changed in the last 5 years, become shorter, thinner or worn?	<input type="checkbox"/>	<input type="checkbox"/>
25. Are your teeth crowding or developing spaces between?	<input type="checkbox"/>	<input type="checkbox"/>
26. Do you have more than one bite and squeeze to make your teeth fit together?	<input type="checkbox"/>	<input type="checkbox"/>
27. 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"/>
28. Do you clench your teeth in the daytime or make them sore?	<input type="checkbox"/>	<input type="checkbox"/>
29. Do you have any problems with sleep or wake up with an awareness of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
30. Do you wear or have you ever worn a bite appliance?	<input type="checkbox"/>	<input type="checkbox"/>
<b>SMILE CHARACTERISTICS</b>		
31. Is there anything about the appearance of your teeth that you would like to change?	<input type="checkbox"/>	<input type="checkbox"/>
32. Have you ever whitened (bleached) your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
33. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
34. Have you been disappointed with the appearance of previous dental work?	<input type="checkbox"/>	<input type="checkbox"/>

Patient/Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_