DENTAL HISTORY

Patient Name__________________________________Nickname:_____________________Date of Birth___________________

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?________________Mth/Yrs

Date (month & year) of last dental visit____________________Date (month & year) of most recent xrays__________________

I routinely see my dentist every (circle one) 3 months 4 months 6 months no routinely

My Main concern is____

Any YES answers listed below you feel free to explain in comments section

PERSONAL HISTORY		
1. Are you fearful of the dentist? If so, how fearful? Scale of 1 (least) to 10 (most) _____________	Y	N
2. Have you had complications or unfavorable dental experiences?	Y	N
3. Have you ever had trouble getting numb or had reaction to local anesthetics?	Y	N
4. Did you ever have braces, orthodontic treatment?	Y	N
5. Have you ever had any teeth extracted/removed?	Y	N
GUM AND BONE		
1. Do your gums bleed or are they painful when brushing or flossing?	Y	N
2. Have you ever been treated for gum / Periodontal Disease?	Y	N
3. Is there a history of Periodontal Disease in your family?	Y	N
4. Have you noticed any unpleasant taste or odor in your mouth?	Y	N
5. Have you ever experienced gum recession?	Y	N
6. Have you ever had any teeth become loose on their own (without injury)?	Y	N
7. Do you have difficulty eating?	Y	N
8. Have you ever experienced burning sensation in your mouth?	Y	N
TOOTH STRUCTURE		
1. Have you had any cavities within the last 3 years?	Y	N
2. Do you or have you ever experienced dry mouth on a regular basis?	Y	N
3. Do you feel or notice any holes (ie pitting, craters) on the biting surface of your teeth?	Y	N
4. Are any teeth sensitive to hot, cold, biting, sweets, or brushing any part of your mouth	Y	N
5. Have you ever broken teeth, chipped teeth or had a toothache or cracked filling?	Y	N
6. Do you frequently get food caught between your teeth?	y	N
BITE AND JAW JOINT		
1. Do you have problems with your jaw joint (pain, popping, limited opening, locking)?	Y	N
2. Do you avoid chewing gum, carrots, nuts, bagels any other hard or crunchy foods?	Y	N
3. Have your teeth changed within last 5 years, become shorter, thinner or worn?	Y	N
4. Do you have crowding or large spaces between teeth?	Y	N
5. Do you have any oral habits such as, (ice chewing, nail biting)?	Y	N
6. Do you realize if you clench or grind your teeth during the day or night?	Y	N
7. Do you have any problems with sleep or wake up with soreness in teeth or jaw joint?	Y	N
8. Do you wear a night guard or bite appliance of any kind?	Y	N
SMILE CHARACTERISTICS		
1. Is there anything about the appearance of your teeth that you would like to change?	Y	N
2. Have you ever whitened your teeth?	Y	N
3. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	Y	N

Comments:____

____

____