DENTAL HISTORY

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 treatment (other than a cleaning)

I routinely see my dentisty 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

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)
2. Have you had an unfavorable dental experience?
3. Have you ever had complications from past dental treatment?
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?
6. Have you had any teeth removed?

GUM & BONE

7. Do your gums bleed or are they painful when brushing or flossing?
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?

9. Have you ever noticed an unpleasant taste or odor in your mouth?
10. Is there anyone with a history of periodontal disease in your family?
11. Have you ever experienced him recession?
12. Have you ever had any teeth become loose on their own (without injury), or do you have difficulty eating an apple?
13. Have you experienced a burning sensation in your mouth?

TOOTH STRUCTURE

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

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or any other hard, dry foods?
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?
25. Are your teeth crowding or developing spaces?
26. Do you have more than one bite and squeeze to make your teeth fit together?
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?
28. Do you clench your teeth in the daytime or make them sore?
29. Do you have any problems with sleep or wake up with an awareness of your teeth?
30. Do you wear or have you ever worn a bite appliance?

SMILE CHARACTERISTICS

31. Is there anything about the appearance of your teeth that you would like to change?
32. Have you ever whitened (bleached) your teeth?
33. Have you felt uncomfortable or self-conscious about the appearance of your teeth?
34. Have you been disappointed with the appearance of the previous dental work?