DENTAL HISTORY

Patient Name: _____ **Date of Birth:** _____

Previous Dentist: _____ **Most Recent Exam:** _____

What is your immediate dental concern: _____

_____

Please answer Y (YES) or N (NO) to the following:

Personal History

1. Are you fearful of dental treatment?	**Y**	**N**
2. Have you had an unfavorable dental experience?	**Y**	**N**
3. Have you ever had complications from past dental experience?	**Y**	**N**
4. Have you ever had braces, orthodontic treatment, or your bite adjusted?	**Y**	**N**
5. Have you ever had trouble with local anesthetic or difficulty getting numb?	**Y**	**N**
6. Have you had any teeth removed?	**Y**	**N**

Smile Characteristics

1. Is there anything about the appearance of your teeth you would change?	**Y**	**N**
2. Have you ever whitened your teeth?	**Y**	**N**
3. Are you self-conscious about your teeth?	**Y**	**N**
4. Have you ever been disappointed with the appearance of previous dental work?	**Y**	**N**

Bite and Jaw Joint

1. Do you have problems with your jaw joint?	**Y**	**N**
2. Do you have problems chewing gum, carrots, bagels, or other hard foods?	**Y**	**N**
3. Have your teeth changed in the last 5 years (become shorter, thinner, or worn)?	**Y**	**N**
4. Are your front teeth close with your natural bite?	**Y**	**N**
5. Do you chew ice, bite your nails, use your teeth to hold objects?	**Y**	**N**
6. Do you clench your teeth in the daytime or make them sore?	**Y**	**N**
7. Do you clench or grind your teeth at night or wake up with sore teeth or jaw?	**Y**	**N**
8. Do you or have you ever worn a bite appliance?	**Y**	**N**

Tooth Structure

1. Have you had cavities in the past 3 years?	**Y**	**N**
2. Do you frequently have dry mouth or have difficulty swallowing?	**Y**	**N**
3. Do you feel or notice any holes on the biting surface of your teeth?	**Y**	**N**
4. Are any teeth sensitive to temperature, biting, or sweets?	**Y**	**N**
5. Do you avoid touching certain areas of your mouth?	**Y**	**N**
6. Do you have any grooves or notches on your teeth near the gumline?	**Y**	**N**
7. Have you ever broken teeth, chipped teeth, or had a cracked filling?	**Y**	**N**
8. Do you get food caught between your teeth?	**Y**	**N**

Gum and Bone

1. Do your gums bleed when brushing, flossing, or eating?	**Y**	**N**
2. Have you ever been treated for gum disease or been told you have bone loss?	**Y**	**N**
3. Have you ever noticed an unpleasant taste or odor in your mouth?	**Y**	**N**
4. Is there anyone with a history of periodontal disease in your family?	**Y**	**N**
5. Have you ever experienced gum recession?	**Y**	**N**
6. Have you ever had any teeth come loose on their own?	**Y**	**N**
7. Have you ever experienced a burning sensation in your mouth?	**Y**	**N**