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DENTAL HISTORY

How would you rate the condition of your mouth? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

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 mo. ❑ 4 mo. ❑ 6 mo. ❑ 12 mo. ❑ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

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 or missing teeth that never developed? _____ ❑ ❑

GUM AND 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 gum recession? _____ ❑ ❑
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ❑ ❑
13. Have you ever experienced a burning or painful sensation in your mouth not related to your teeth? _____ ❑ ❑

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 filling? _____ ❑ ❑
20. Do you frequently get food caught between any teeth? _____ ❑ ❑

Complete Reverse Side

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

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 other hard, dry foods? __ ❑ ❑
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ❑ ❑
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ❑ ❑
26. Are your teeth developing spaces or becoming more loose? _____ ❑ ❑
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____ ❑ ❑
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ ❑ ❑
29. Do you chew ice, chew gum, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ❑ ❑
30. Do you clench your teeth in the daytime or make them sore? _____ ❑ ❑
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____ ❑ ❑
32. Do you wear or have you ever worn a bite appliance? _____ ❑ ❑

SMILE CHARACTERISTICS

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

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ADDITIONAL COMMENTS