DENTAL HISTORY



Nar	me Nickname Age		
	erred by How would you rate the condition of your mouth?	☐Fair	Poor
Pre	vious DentistMonths/Years e of most recent dental exam//Date of most recent x-rays//		
Dat	e of most recent dental exam		
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
P	ERSONAL HISTORY O		
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?		\Box
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted?		\bigcup
6.	Have you had any teeth removed or missing teeth that never developed?	_ U	U
G	SUM 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?	_ U	\Box
10.	Is there anyone with a history of periodontal disease in your family?	_ U	\bigcup
11.	Have you ever experienced gum recession? Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?		
12.			
13.	, ,	_ U	U
TOOTH STRUCTURE			
14.			
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. 20.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?		
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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?	_ U	\Box
24.	Have your teeth changed in the last 5 years, become shorter, thinner or worn?	_ U	\Box
25. 26.	Are your teeth becoming more crooked, crowded, or overlapped?		
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?	- 0	
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?		$\tilde{\Box}$
30.	Do you clench your teeth in the daytime or make them sore?		$\tilde{\Box}$
31.	Do you clench your teeth in the daytime or make them sore?		$\ddot{\Box}$
32.	Do you wear or have you ever worn a bite appliance?		Ō
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?		
Pati	ent's SignatureDate		
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