Dental History

Patient Name: _____ Age: _____
Previous Dentist: _____ How long had you been a patient? _____
Date of most recent dental exam: ____/____/_____ Date of most recent x-rays:____/____/____
Date of most recent treatment (other than a cleaning): ____/____/____
How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair
I routinely see my dentist every: ☐ 3 mon. ☐ 4 mon. ☐ 6 mon. ☐ 12 mon. ☐ Not Routinely
What is your immediate concern?
_____
_____

	YES	NO
Personal History:		
1. Have you had an unfavorable dental experience? _____	☐	☐
2. Have you ever had complications from past dental experience? _____	☐	☐
3. Have you ever had trouble getting numb or had any reactions to local anesthetic_____	☐	☐
4. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	☐	☐
5. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____	☐	☐
Gum and Bone:		
6. Do your gums bleed sometimes or are they ever painful when brushing or flossing? _____	☐	☐
7. Have you ever been treated for gum disease or been told you have bone loss around your teeth? _____	☐	☐
8. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
9. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
10. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____	☐	☐
11. Have you ever had any teeth become loose on their own (without any injury), or do you have difficulty eating an apple? _____	☐	☐
12. Have you ever experienced a burning or painful sensation in your mouth not related to your teeth? _____	☐	☐
Tooth Structure:		
13. Have you had any cavities within the past 3 years? _____	☐	☐
14. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
15. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
16. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing part of your mouth? _____	☐	☐
17. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
18. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
19. Do you frequently get food caught between any teeth? _____	☐	☐
Bite and Jaw:		
20. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)_____	☐	☐
21. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	☐	☐
22. Do you avoid or have trouble chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?_____	☐	☐
23. In the past 5 years, have your teeth changed (becoming shorter, thinner, or worn) or has your bite changed? _____	☐	☐
24. Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
25. Are your teeth developing spaces or becoming looser? _____	☐	☐
26. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _____	☐	☐
27. Do you hold your tongue between your teeth? _____	☐	☐
28. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
29. Do you clench or grind your teeth together in the daytime or make them sore? _____	☐	☐
30. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____	☐	☐
31. Do you wear or have you ever worn a bite appliance? _____	☐	☐
Smile Characteristics:		
32. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)? _____	☐	☐
33. Have you ever whitened (bleached) your teeth? _____	☐	☐
34. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
35. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient's signature: _____Date:_____

Doctor's signature:_____Date:_____