Dental History

How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist________________________________How long have you been a patient__________
Date of most recent dental exam_____/_____/_____ Date of most recent xrays_____/_____/_____
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? Scale of 1 to 10 (very) _____	Y	N
2. Have you had an unfavourable dental experience?	Y	N
3. Have you ever had complications from past dental treatment?	Y	N
4. Have you ever had trouble getting numb or reactions to local anesthetic?	Y	N
5. Have you ever had braces, orthodontic treatment or had your bite adjusted?	Y	N
6. Have you had any teeth removed?	Y	N
(for office use only) **L M H**		
Smile Characteristics		
7. Is there anything about the appearance of your teeth that you would like to change?	Y	N
8. Have you ever whitened (bleached) your teeth?	Y	N
9. Are you self conscious about your teeth?	Y	N
10. Have you ever been disappointed with the appearance of previous dental work?	Y	N
(for office use only) **L M H**		
Bite and Jaw Joint		
11. Do you / would you have any problems chewing gum?	Y	N
12. Do you / would you have any problems chewing bagels or other hard foods?	Y	N
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	Y	N
14. Are your teeth crowding or developing spaces?	Y	N
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	Y	N
16. Do you have any problems with sleep or wake up with an awareness of your teeth?	Y	N
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	Y	N
18. Do you have tension headaches or sore teeth?	Y	N
19. Do you wear or have you ever worn a bite appliance?	Y	N
(for office use only) **L M H**		
Tooth Structure		
20. Have you had any cavities within the past 3 years?	Y	N
21. Do you have a dry mouth?	Y	N
22. Are any teeth sensitive to hot, cold, biting, or sweets?	Y	N
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?	Y	N
(for office use only) **L M H**		
Gum and Bone		
24. Have you ever been diagnosed or treated for periodontal (gum) disease?	Y	N
25. Have you ever experienced gum recession?	Y	N
26. Is there anyone with a history of periodontal disease in your family?	Y	N
27. Do your gums bleed when brushing, flossing or eating?	Y	N
28. Are your teeth becoming loose?	Y	N
29. Have you ever noticed an unpleasant taste or odor in your mouth?	Y	N
30. Have you experienced a burning sensation in your mouth?	Y	N
(for office use only) **L M H**		

Patient's Signature____Date_________________________
Doctor's Signature____Date_________________________