DENTAL HISTORY

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

Previous Dentist______________________________

Date of most recent dental exam_________________ Date of most recent x-rays____________________

Date of most recent treatment___________________ Date of last dental cleaning___________________

I routinely see my dentist every: ☐ 3mo ☐ 4mo ☐ 6mo ☐ 12mo ☐ Not routinely

WHAT IS YOUR IMMEDIATE DENTAL CONCERN?______________________________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY ☐ L ☐ M ☐ H	YES	NO
1. Are you fearful of dental treatment?	☐	☐
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 reactions to local anesthetic?	☐	☐
5. Did you ever have braces or had your bite adjusted? If so, when?__________________	☐	☐
6. Have you had any teeth removed?	☐	☐
7. Do you have dentures or partial dentures?	☐	☐
8. Do you often feel tired, fatigued, have a hard time concentrating?	☐	☐
SMILE CHARACTERISTICS ☐ L ☐ M ☐ H		
9. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
10. Have you ever whitened (bleached) your teeth?	☐	☐
11. Are you self-conscious about your teeth?	☐	☐
12. Have you been disappointed with the appearance of previous dental work?	☐	☐
BITE & JAW JOINT ☐ L ☐ M ☐ H		
13. Do you/would you have any problems chewing gum?	☐	☐
14. Do you/would you have any problems chewing bagels or other hard foods?	☐	☐
15. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
16. Are your teeth crowding, developing spaces or catching food?	☐	☐
17. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	☐	☐
18. Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
19. Do you snore?	☐	☐
20. Do you have sleep apnea?	☐	☐
21. Have you ever had a sleep test/study?	☐	☐
22. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
23. Do you have tension headaches or sore teeth?	☐	☐
24. Do you wear or have you ever worn a bite appliance?	☐	☐
TOOTH STRUCTURE ☐ L ☐ M ☐ H		
25. Have you had any cavities within the past 3 years?	☐	☐
26. Do you have a dry mouth?	☐	☐
27. Do you regularly breathe through your mouth?	☐	☐
28. Are any teeth sensitive to hot, cold, biting or sweets?	☐	☐
29. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?	☐	☐
30. Do you avoid brushing any part of your mouth?	☐	☐
31. Do you feel or notice any holes (ie. pitting) in your teeth?	☐	☐
32. Do you bite your nails or chew on objects with your front teeth?	☐	☐
33. Is your sugar intake: ☐ low ☐ moderate ☐ high		
34. Where does sugar come from in your diet? ________________________________		
GUM & BONE ☐ L ☐ M ☐ H		
35. Have you ever been diagnosed or treated for periodontal (gum) disease?	☐	☐
36. Have you ever experienced gum recession?	☐	☐
37. Is there anyone with a history of periodontal disease in your family?	☐	☐
38. Do your gums bleed when brushing, flossing or eating?	☐	☐
39. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
40. Have you experienced a burning sensation in your mouth?	☐	☐
41. How often do you brush: teeth______________tongue _____________floss________________		
42. Do you use any of the following: ☐ electric toothbrush ☐ floss aids ☐ mouthrinse ☐ specialty toothpaste		