

DENTAL HISTORY

Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
 Previous Dentist _____ How long have you been a patient? _____ Months/Years
 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) [] _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Have you had an unfavorable dental experience? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Have you ever had complications from past dental treatment? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | Have you had any teeth removed? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

SMILE CHARACTERISTICS

- | | | | |
|-----|---|--------------------------|--------------------------|
| 7. | Is there anything about the appearance of your teeth that you would like to change? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | Have you ever whitened (bleached) your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | Have you been disappointed with the appearance of previous dental work? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

BITE AND JAW JOINT

- | | | | |
|-----|--|--------------------------|--------------------------|
| 11. | Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. | Do you / would you have any problems chewing gum? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. | Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. | Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. | Are your teeth crowding or developing spaces? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. | Do you have more than one bite and squeeze to make your teeth fit together? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. | Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. | Do you clench your teeth in the daytime or make them sore? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. | Do you have any problems with sleep or wake up with an awareness of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. | Do you wear or have you ever worn a bite appliance? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

TOOTH STRUCTURE

- | | | | |
|-----|--|--------------------------|--------------------------|
| 21. | Have you had any cavities within the past 3 years? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. | Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. | Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. | Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. | Do you have grooves or notches on your teeth near the gum line? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. | Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. | Do you get food caught between any teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

GUM AND BONE

- | | | | |
|-----|---|--------------------------|--------------------------|
| 28. | Do your gums bleed when brushing or flossing? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. | Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. | Have you ever noticed an unpleasant taste or odor in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. | Is there anyone with a history of periodontal disease in your family? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. | Have you ever experienced gum recession? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. | Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. | Have you experienced a burning sensation in your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____