



DENTAL HISTORY

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

Date of most recent dental exam ____/____/____ Date of most recent dental X-Ray ____/____/____

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:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? Scale of 1 to 10 (very).....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had an unfavorable dental experiences?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had complications	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had trouble getting numb or 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. Are you self conscious about your teeth:	<input type="checkbox"/>	<input type="checkbox"/>
BITE AND JAW JOINT		
10. Do you have any problems chewing gum?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have any problems chewing bagels or other hard foods?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	<input type="checkbox"/>	<input type="checkbox"/>
14. Are your teeth crowding or developing spaces?.....	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?.....	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you have any problems with sleep or wake up with an awareness of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have tension headaches or sore teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you wear or have you ever worn a bite appliance?	<input type="checkbox"/>	<input type="checkbox"/>
TOOTH STRUCTURE		
20. Have you had any cavities within the past 3 years?.....	<input type="checkbox"/>	<input type="checkbox"/>
21. Do you have a dry mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>
22. Are any teeth sensitive to hot, cold, biting or sweets?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you avoid brushing or flossing any part of your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>
GUM AND BONE		
25. Have you ever been diagnosed or treated for periodontal (gum) disease?	<input type="checkbox"/>	<input type="checkbox"/>
26. Have you ever experienced gum recession?	<input type="checkbox"/>	<input type="checkbox"/>
27. Is there anyone with a history of periodontal disease in your family?	<input type="checkbox"/>	<input type="checkbox"/>
28. Do your gums bleed when brushing, flossing or eating?	<input type="checkbox"/>	<input type="checkbox"/>
29. Are your teeth becoming loose?	<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. Have you experienced a burning sensation in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Signature _____ Date _____