

Dental History

Name: _____ Birthdate: _____

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: 3mo 4mo 6mo 12mo not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

- 1 Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most) [____] _____
- 2 Have you had an unfavourable dental experience? _____
- 3 Have you ever had complications from past dental treatment? _____
- 4 Have you ever had trouble getting numb or had any reactions to local anesthetic _____
- 5 Did you ever have any braces, orthodontic treatment or had your bite adjusted? _____
- 6 Have you had any teeth removed? _____

YES NO

GUM AND BONE

- 7 Do your gums bleed or are they painful when brushing or flossing? _____
- 8 Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
- 9 Have you ever noticed an unpleasant taste or odour in your mouth _____
- 10 Is there anyone with a history of periodontal disease in your family? _____
- 11 Have you ever experienced gum recession? _____
- 12 Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
- 13 Have you experienced a burning sensation in your mouth? _____

TOOTH STRUCTURE

- 14 Have you had any cavities within the past 3 years? _____
- 15 Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
- 16 Do you feel or notice any holes (ie pitting, craters) in the biting surfaces of your teeth? _____
- 17 Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____
- 18 Do you have grooves or notches on your teeth near the gum line? _____
- 19 Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
- 20 Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT

- 21 Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
- 22 Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____
- 23 Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
- 24 Have your teeth changed in the last 5 years, become shorter, thinner, or worn? _____
- 25 Are your teeth crowding or developing spaces? _____
- 26 Do you have more than one bite and squeeze to make your teeth fit together? _____
- 27 Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
- 28 Do you clench your teeth in the daytime or make them sore? _____
- 29 Do you have any problems with sleep or wake up with an awareness of your teeth _____
- 30 Do you wear or have you ever worn a bite appliance? _____
- 31 Do you place your tongue between your teeth or rest your teeth against your tongue? _____
- 32 Are you teeth becoming more crooked, crowded, or overlapped? _____

SMILE CHARACTERICS

- 33 Is there anything about the appearance of your teeth that you would like to change? _____
- 34 Have you ever whitened (bleached) your teeth? _____
- 35 Have you ever felt uncomfortable or self-conscious about the appearance of your teeth? _____
- 36 Have you been disappointed with the appearance of previous dental work? _____
