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	**YES**	**NO**
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? _____		
	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? _____		

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____