

Name: _____ Nickname: _____ Age: _____

Referred by: _____ 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 _____ Dental X-rays _____ Treatment (other than 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)? [____]
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 had any reactions to local anesthetic?
5. Have you ever had braces, had orthodontic treatment or had your bite adjusted?
6. Have you had any teeth removed or are you missing teeth that never developed?

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 odor 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 or painful sensation in your mouth not related to your teeth?

Tooth Structure

14. Have you had any cavities within the past 3 years?
15. Does the saliva in your mouth seem too little, or do you have difficulty swallowing any food?
16. Do you notice any holes (i.e. pitting, craters) on the surface of your teeth?
17. Are any teeth sensitive to hot, cold, biting, or sweets, or do you avoid brushing any part of your mouth?
18. Do you have grooves or notches on your teeth near the gumline?
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 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 becoming more crooked, crowded, or overlapped?
26. Are your teeth developing spaces or becoming more loose?
27. Do you have to shift your jaw to make your teeth fit together?
28. Do you place your tongue between your teeth or close your teeth against your tongue?
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?
30. Do you clench your teeth in the daytime or make them sore?
31. Do you have any problems with sleep (i.e. restlessness), or wake up with a headache or an awareness of your teeth?
32. Do you wear or have you ever worn a bite appliance?

Smile Characteristics

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 felt uncomfortable or self-conscious about the appearance of your teeth?
36. Have you been disappointed with the appearance of previous dental work?

Signature of Patient, Parent or Guardian: _____ Date: _____

Dr's Signature / Medical History Review: _____ Date: _____