DENTAL HISTORY

Patient Name____DOB ____________

On a scale of 1 to 10 (with 10 being completely healthy), where do you rate your current level of oral health? ________

Previous Dentist______________________________How long have you been a patient there?______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 months □ 4 months □ 6 months □ 12 months □ Not routinely

My main dental concern is ____

	Yes	No
PERSONAL HISTORY		
1. Are you fearful of dental treatment? If so, 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. Did you ever have 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 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 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 (i.e. pitting, craters) on the biting surface of your teeth?	□	□
17. Are any teeth sensitive to hot, cold, biting, sweets, or 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 you teeth changed in the last 5 years, become shorter, thinner or worn?	□	□
25. Are your teeth crowding or developing spaces between?	□	□
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?	□	□
SMILE CHARACTERISTICS		
31. Is there anything about the appearance of your teeth that you would like to change?	□	□
32. Have you ever whitened (bleached) your teeth?	□	□
33. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	□	□
34. Have you been disappointed with the appearance of previous dental work?	□	□
SLEEP AND AIRWAY HEALTH		
35. Do you have any sleep concerns?	□	□
36. Do you wake frequently at night?	□	□
37. Have you been diagnosed with Sleep Apnea?	□	□
38. Do you use a CPAP machine? If so, how many hours/night? _________ How many days/week? __________	□	□

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Patient/Parent/Guardian Signature Date