Dental History

Name____ Nickname______________________

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

How would you rate your oral hygiene (home care of teeth)? ☐ 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: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 2 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN?____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**
PERSONAL HISTORY	
Do you require premedication prior to dental treatment.	☐
Have you had an unfavorable dental experience?	☐
Have you ever had complications from past dental treatment?	☐
Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐
Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐
Do you snore or have sleep apnea	☐
GUM AND BONE	
Do your gums bleed or are they painful when brushing or flossing?	☐
Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐
Have you ever experienced gum recession?	☐
TOOTH STRUCTURE	
Have you had any cavities within the past 3 years?	☐
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐
Do you frequently get food caught between any teeth?	☐
BITE AND JAW JOINT	
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐
Are your teeth crowding or developing spaces?	☐
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐
Do you clench or grind your teeth in the daytime or night time, or wake up with pain in teeth / jaw?	☐
Do you wear or have you ever worn a bite appliance?	☐
SMILE CHARACTERISTICS	
Is there anything about the appearance of your teeth that you would like to change?	☐

Patient's Signature ____ Date __________________

Doctor's Signature ____ Date __________________