Dental History

Name____ DOB_______________________
Rate the condition of your mouth __Excellent__Good__Fair__Poor
Previous Dentist______________________ Last Seen__________________________
Date of last dental Exam_________________ Date of last dental x-rays____________________
Date of last dental treatment other than cleaning_______________________ Treatment_________________

What is your immediate concern? ____

PLEASE ANSWER YES OR NO TO FOLLOWING:	*YES*	*NO*
1. Are you fearful of dental treatment?	___	___
2. Have you had an unfavorable experience? _______________________________	___	___
3. Have you ever had complications from past dental treatment? ________________	___	___
4. Have you ever had trouble getting numb or had a reaction to local anesthetic? ___	___	___
5. Did you ever have braces, orthodontic treatment, or bite adjusted? ____________	___	___
By whom? ______________________________		
Was orthodontic treatment ever recommended?	___	___
6. Have you bleached/whitened your teeth in the past? ____________________	___	___
7. Do your gums bleed or are they painful when brushing or flossing? ____________	___	___
Do you smoke or chew tobacco? ___________________________________	___	___
8. Have you ever been treated for gum disease or been told you have bone loss? ___	___	___
Have you had Root Planing or Deep Cleaning? When? _________________	___	___
Have you had Gum Surgery? When? _______________________________	___	___
Are you currently under the care of a Periodontist (Gum Specialist)? _______	___	___
9. Have you ever noticed an unpleasant taste or odor in your mouth? ____________	___	___
10. Is there anyone in your family with periodontal disease? ____________________	___	___
11. Have you had any cavities within the past 3 years? _______________________	___	___
12. Does your mouth feel dry or do you have trouble swallowing your food? ______	___	___
13. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing in areas? ___	___	___
14. Do you have grooves or notches on your teeth next to the gum line? ___________	___	___
15. Have you ever broken teeth, chipped teeth, had a cracked filling? _____________	___	___
16. Do you frequently get food caught between any teeth? _____________________	___	___
17. Do you have problems with your jaw joint? (pain, limited opening, locking)_____	___	___
18. Have your teeth changed in the last 5 years, become shorter, thinner, worn? _____	___	___
19. Are your teeth becoming more crowded, crooked? _________________________	___	___
20. Are your teeth developing spaces or becoming looser? __________________ ___	___	
21. Do you chew ice, bite your nails, or use your teeth to hold objects? ____________	___	___
22. Do you clench your teeth in the daytime and make them sore? _______________	___	___
23. Do you have trouble sleeping, wake up with a headache or an awareness of teeth?	___	___
24. Do you wear or have ever worn a bite appliance? __________________________	___	___
25. Is there anything about the appearance of your teeth you would like to change?	___	___

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Patient's signature____ Date_________________
Doctor's/Hygienist signature_____________________________________ Date_________________