Dental History Form

Patient Name _____ Age _____

Referred by_____ Previous Dentist's name _____ How long?_____

Date of most recent dental exam ____ /____ /____ I see my Dentist (circle): 3 m, 6 m, 12m, other, not routinely

What is your immediate concern? _____

On a scale of 1-10 (10 greatest), how important is your dental health?	1	2	3	4	5	6	7	8	9	10
On a scale of 1-10 (10 greatest), how would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
On a scale of 1-10 (10 greatest, how fearful are you of dental treatment?	1	2	3	4	5	6	7	8	9	10

Personal History	**Yes**	**No**
1. Have you had an unfavorable dental experience?	☐	☐
2. Have you ever had complications from past dental treatment?	☐	☐
3. Have you ever had trouble getting numb or had any reactions to local anesthesia?	☐	☐
4. Do you have, or have you had any teeth removed or teeth that never developed?	☐	☐
5. Did you ever have orthodontic treatment, braces, or your bite adjusted?	☐	☐

Gum/Bone History - Periodontal	**Yes**	**No**
6. Do your gums bleed or do they hurt during brushing/flossing?	☐	☐
7. Have you ever been told you have gum disease or are losing bone around your teeth?	☐	☐
8. Have you ever noticed an unpleasant taste/smell in your mouth?	☐	☐
9. Does anyone in your family have a history of periodontal/gum disease?	☐	☐
10. Have you experienced gum recession (teeth look longer)?	☐	☐
11. Have you ever had any teeth become loose on their own?	☐	☐

Tooth Structure History - Cavities	**Yes**	**No**
12. Have you had any cavities within the past 3 years?	☐	☐
13. Does the amount of your saliva in your mouth seem to little or do you have trouble eating/swallowing food?	☐	☐
14. Do you feel or notice any holes on the tops of your teeth?	☐	☐
15. Are your teeth sensitive to hot, cold, biting, sweets, etc or do you avoid brushing any area?	☐	☐
16. Do you have grooves or notches on your teeth near the gum line?	☐	☐
17. Have you ever broken, chipped, cracked any teeth or had a toothache?	☐	☐
18. Do you get food caught between your teeth?	☐	☐

Occlusion History - Bite, Jaw & TMJ	**Yes**	**No**
19. Do you have problems with your jaw joint? (pain, popping, cracking, locking, etc.)	☐	☐
20. Do you avoid chewing gum, carrots, nuts, hard or chewy foods?	☐	☐
21. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
22. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
23. Are your teeth developing spaces or becoming loose?	☐	☐
24. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?	☐	☐
25. Do you clench your teeth during the day or night or wake with a headache?	☐	☐
26. Do you wear, or have you ever worn, a bite appliance?	☐	☐

Cosmetic History - Smile	**Yes**	**No**
27. Is there anything about your appearance of your teeth that you would like to change?	☐	☐
28. Have you ever whitened/bleached your teeth?	☐	☐
29. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
30. Have you been disappointed with the appearance of previous dental work?	☐	☐