DENTAL HISTORY

Patient name_____
Referred by_____
Previous dentist_____
Last dental exam_____ Last dental x-rays_____
Last dental treatment_____
How often do you have your teeth cleaned? 3mo. ____ 4mo. ____ 6mo. ____ 1 year or longer ____
How often do you brush your teeth? _____Floss? _____Use any dental aids? _____
WHAT IS YOUR IMMEDIATE DENTAL CONCERN?
_____
_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

1. Would you like to keep your teeth all your life---------- ☐ ☐
2. Unhappy with appearance of your teeth---------- ☐ ☐
3. Are you interested in whitening/bleaching your teeth? ---------- ☐ ☐
4. Unfavorable/upsetting dental experiences---------- ☐ ☐
5. Dental fears---------- ☐ ☐
6. Problems with effectiveness or bad reactions to dental anesthesia---------- ☐ ☐
7. Orthodontic Treatment (braces) when _____---------- ☐ ☐
8. Periodontal (gum) treatment---------- ☐ ☐
9. Bleeding or painful gums (even occasionally)---------- ☐ ☐
10. Avoid brushing any part of your mouth---------- ☐ ☐
11. Parts of mouth sensitive to temperature, sweets or chewing---------- ☐ ☐
12. Sore teeth---------- ☐ ☐
13. Difficulty swallowing---------- ☐ ☐
14. Unpleasant taste or odor in your mouth---------- ☐ ☐
15. Dry mouth---------- ☐ ☐
16. Jaw problems (temporomandibular joints)---------- ☐ ☐
17. Do you/would have any problems chewing gum---------- ☐ ☐
18. Do you/would you have any problems chewing bagels or other hard foods---------- ☐ ☐
19. Difficulty opening mouth widely---------- ☐ ☐
20. Jaw ever become stuck---------- ☐ ☐
21. Stiff neck or shoulder muscles---------- ☐ ☐
22. Awaken with an awareness of your teeth or jaws---------- ☐ ☐
23. Headaches---------- ☐ ☐
24. Clenching or grinding your teeth---------- ☐ ☐
25. Do you have more then one bite or do you clench (squeeze) to make your teeth fit together---------- ☐ ☐
26. Have your teeth changed within the last 5 years, become shorter, thinner or worn---------- ☐ ☐
27. Do you chew on both sides of your mouth---------- ☐ ☐
28. Do you ever experience clicking, popping or grating of your jaw joints---------- ☐ ☐
29. Lost any teeth---------- ☐ ☐
30. Smoke/chew tobacco---------- ☐ ☐
31. Desire to set goals and plan for excellent long term dental health---------- ☐ ☐
32. Do strange people or places make you afraid---------- ☐ ☐
33. Do you have any problems with sleeping or do you have any sleep disorders---------- ☐ ☐

OVER ⇒

	YES	NO
34. Is there anything else about having dental treatment that we should know----------	☐	☐

35. If yes, please explain

_____

_____

_____

PLEASE CIRCLE ONE:

1. My mouth is:
   a. very comfortable
   b. moderately comfortable
   c. uncomfortable

2. I:
   a. think the appearance of my mouth is excellent.
   b. think the appearance of my mouth is adequate.
   c. wish I could change the appearance of my mouth.

3. I:
   a. want to save my teeth at all costs.
   b. prefer to keep my teeth if cost and time are reasonable.
   c. expect to someday lose my teeth and have dentures.

4. I:
   a. have set goals to achieve optimum oral health with a previous dentist.
   b. want to set goals to achieve optimum oral health.
   c. am not very interested in setting personal goals to achieve optimum oral health.

5. I:
   a. have followed the recommendations for optimum dental health given by my dentist.
   b. have not done what dentists have recommended I do with my mouth.
   c. usually only go to the dentist for emergencies.

6. I think I:
   a. am in EXCELLENT oral health.
   b. am in GOOD oral health.
   c. am in POOR oral health.

7. I desire:
   a. excellent oral health.
   b. average or good oral health.
   c. crisis care only.

8. What are some questions about dentistry and your oral health that you have never had adequately answered?_____

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture please complete the following:	YES	NO
1. Has your present partial or denture been relined? When _____----------	☐	☐
2. Is your present partial or denture a problem----------	☐	☐
3. If yes, describe _____		
4. Satisfied with the appearance----------	☐	☐
5. Satisfied with the comfort----------	☐	☐
6. Satisfied with your chewing ability----------	☐	☐

When did you receive your first partial or complete denture? _____

How long have you had your current partial or complete denture? _____

Patient's Signature_____Date_____