dillinghamhanson

Family, Cosmetic, & Implant Dentistry

DENTAL HISTORY

Name:_____ Age:_____ Date:_____

What is your immediate concern? Why did you schedule a visit with us today?_____

_____

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

Previous Dentist:_____ How long had you been a patient?_____

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

PLEASE MARK "YES" OR "NO" TO THE FOLLOWING:

PERSONAL HISTORY:

1. Are you fearful of dental treatment? ◯ Yes ◯ No
   a. How fearful, on a scale of 1 (least) to 10 (most)? _____
2. Have you ever had an unfavorable dental experience? ◯ Yes ◯ No
3. Have you ever had complications from past dental treatment? ◯ Yes ◯ No
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ◯ Yes ◯ No
5. Have you ever had braces/orthodontics? ◯ Yes ◯ No
   a. If so, at what age? _____
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? ◯ Yes ◯ No

GUM AND BONE:

7. Do your gums bleed or are they painful when brushing or flossing? ◯ Yes ◯ No
8. Have you ever been treated for gum disease or been told you have lost gum or bone around your teeth? ◯ Yes ◯ No
9. Have you ever noticed an unpleasant taste or odor in your mouth? ◯ Yes ◯ No
10. Is there anyone in your family with a history of periodontal disease (gum disease)? ◯ Yes ◯ No
11. Have you ever experienced gum recession? ◯ Yes ◯ No
12. Have you ever had your teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ◯ Yes ◯ No
13. Have you ever experienced a burning or painful sensation in your mouth not related to your teeth? ◯ Yes ◯ No

TOOTH STRUCTURE:

14. Have you had any cavities (decay) within the past 3 years? ◯ Yes ◯ No
15. Do you feel like your mouth is dry on a regular basis? ◯ Yes ◯ No
16. Do you have trouble swallowing? ◯ Yes ◯ No
17. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ◯ Yes ◯ No
18. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? ◯ Yes ◯ No
19. Do you have grooves or notches on your teeth near the gum line? ◯ Yes ◯ No
20. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ◯ Yes ◯ No
21. Do you frequently get food caught between any teeth? ◯ Yes ◯ No

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BITE AND JAW JOINT:

22. Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)? ◯ Yes ◯ No
23. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? ◯ Yes ◯ No
24. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ◯ Yes ◯ No
25. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? ◯ Yes ◯ No
26. Are your teeth becoming more crooked, crowded, or overlapped? ◯ Yes ◯ No
27. Are your teeth developing spaces or becoming looser? ◯ Yes ◯ No
28. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? ◯ Yes ◯ No
29. Do you place your tongue between your teeth or close your teeth against your tongue? ◯ Yes ◯ No
30. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ◯ Yes ◯ No
31. Do you clench or grind your teeth together in the daytime or make them sore? ◯ Yes ◯ No
32. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ◯ Yes ◯ No
33. Do you wear or have you ever worn a bite appliance? ◯ Yes ◯ No

SMILE CHARACTERISTICS:

34. Is there anything about the appearance of your teeth or smile that you would like to change (shape, color, size, etc.)? ◯ Yes ◯ No
35. Have you ever whitened (bleached) your teeth? ◯ Yes ◯ No
36. Have you ever felt uncomfortable or self-conscious about the appearance of your teeth? ◯ Yes ◯ No
37. Have you been disappointed with the appearance of previous dental work? ◯ Yes ◯ No

Patient's Signature:_____ Date:_____

Dentist's Signature:_____ Date:_____

For office use:

NOTES: