# Dental History

Patient Name: _____

Reason for today's visit: _____ _____ _____

How often do you routinely see the dentist? □ 3 months □ 4months □ 6months □ Not routinely

Please rate your anxiety/fear of dental treatment: □ 0 □ 1-3 □ 4-6 □ 7-9 □ 10(or more)

How you had an unfavorable dental experience? □ Yes □ No

Ever had complications with past dental treatment? □ Yes □ No

Ever had trouble getting numb or had any reaction to anesthetic? □ Yes □ No

Do you have an immediate dental concern? □ Yes □ No If yes: _____

**Bite and Jaw Joint**

Do you have any problems with your jaw joint? (Pain, sounds, limited opening, locking, popping) □ Yes □ No

Do you have any problems chewing bagels, protein bars, or other hard foods? □ Yes □ No

Have your teeth changed in the last 5 years, become shorter, thinner, or worn out? □ Yes □ No

Are your teeth crowding or developing spaces? □ Yes □ No

Do you have more than one bite and squeeze to make your teeth fit together? □ Yes □ No

Do you have any problems with sleep, or wake up with an awareness of your teeth or jaw? □ Yes □ No

Have you ever worn a bite appliance? □ Yes □ No

**Smile Characteristics**

Is there anything about the appearance of your teeth you would like to change? □ Yes □ No

Would you like your teeth whiter? □ Yes □ No

Have you felt uncomfortable or self-conscious about the appearance of your teeth? □ Yes □ No

Have you been disappointed with the appearance of previous dental work? □ Yes □ No

**Tooth Structure**

Have you had any cavities in the last 3 years? □ Yes □ No

Does your mouth feel dry or do you have difficulty swallowing food? □ Yes □ No

Do you feel or notice any holes, pits, or craters in your teeth? □ Yes □ No

Are your teeth sensitive to hot, cold, biting, or sweets? □ Yes □ No

Do you avoid brushing any part of your mouth? □ Yes □ No

Do you have grooves or notches on your teeth near the gum line? □ Yes □ No

Do you frequently get food caught between your teeth? □ Yes □ No

**Gum and Bone**

Do your gums bleed or are they painful when you brush or floss? □ Yes □ No

Have you ever been treated for gum disease or told you have lost bone? □ Yes □ No

Have you ever noticed an unpleasant taste or odor in your mouth? □ Yes □ No

Is there anyone in your family with a history of periodontal disease? □ Yes □ No

Have you ever experienced gum recession? □ Yes □ No

Have you ever had teeth become loose (without injury) or have difficulty eating? □ Yes □ No

Have you ever had a burning sensation in your mouth? □ Yes □ No

Signature of Patient, Parent, or Guardian: Date: