Lifetime Dental Care: Dental History

Name:_____ Age: _____ Referred by: _____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor Previous Dental Practice? _____

How long have you been a patient at your previous practice? _____ Months/Years How long ago was your last dental visit? _____/_____/_____

Date of most recent treatment (other than a cleaning) _____/___/_____ Date of most recent cleaning ____/___/____ By hygienist ☐ By dentist ☐

I routinely see my dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

What is your immediate concern? _____

Please answer Yes or No to the following:

Personal History	**Yes**	**No**
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) (___) _____	☐	☐
2. Have you had an unfavourable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anaesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6. Have you ever had any teeth removed? _____	☐	☐
Gum and Bone		
7. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste or odour in your mouth? _____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11. Have you ever experienced gum recession? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury)? _____	☐	☐
13. Are your teeth developing spaces? _____	☐	☐
14. Have you experienced a burning sensation in your mouth? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐

Tooth Structure	**Yes**	**No**
16. Have you had any cavities within the past 3 years? _____	☐	☐
17. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
18. Are any teeth sensitive to hot, cold, biting or sweets or do you avoid brushing any part of your mouth? _____	☐	☐
19. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
20. Have you ever broken, chipped or cracked teeth or fillings? _____	☐	☐
21. Have you ever had a toothache? _____	☐	☐
22. Do you frequently get food caught between any teeth? _____	☐	☐
Bite and Jaw Joint		
23. Do you have any problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
24. Do you avoid or have difficulty chewing hard or sticky foods e.g. Carrots, sweets? _____	☐	☐
25. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
26. Are your teeth becoming more crooked, crowded or overlapped? _____	☐	☐
27. Do you have trouble biting your teeth together? _____	☐	☐
28. Do you chew ice, bite your nails or use your teeth to hold objects? _____	☐	☐
29. Do you clench and grind your teeth in the daytime or make them sore? _____	☐	☐
30. Do you have any problems with sleep (i.e. Restlessness), wake up with a headache or an awareness of your teeth? _____	☐	☐
31. Do you wear or have ever worn a bite appliance? _____	☐	☐
Smile Characteristics		
32. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
33. Have you ever whitened (bleached) your teeth? _____	☐	☐
34. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient Signature _____ **Date** _____/_____/_____