DENTAL HISTORY

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

Previous Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long were you a patient? \_\_\_\_\_\_\_\_\_\_Months/Years

When was your last exam and cleaning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WHAT IS YOUR IMMEDIATE CONCERN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE ANSWER THE FOLLOWING:**

1 2 3 4 5 6 7 8 9 10

1. On a scale of 1 (least) to 10 (most), how fearful are you of dental treatment?
2. Have you had any complications or unfavorable dental experiences? **Yes/No**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you ever had trouble getting numb or had any reactions to local anesthetic? **Yes/No** \_\_\_\_\_\_\_\_\_\_\_\_
4. Did you ever have braces or orthodontic treatment? **Yes/No** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Do you clench or grind your teeth during the day and/or at night? **Yes/No** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Do you have chronic headaches, neck, or shoulder pain? **Yes/No** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Are your teeth or jaw joints sore or tired when you wake up? **Yes/No**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Does your jaw painfully click or pop when you open your mouth? **Yes/No**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Have you ever experienced difficult moving your jaw or opening your mouth wide? **Yes/No**\_\_\_\_\_\_\_\_\_\_\_\_
10. Do you chew on only one side of your mouth? **Yes/No**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. Is there anything about the appearance of your teeth that you’d like to change? **Yes/No** \_\_\_\_\_\_\_\_\_\_\_\_\_\_
12. Are your teeth crowding or developing spaces? **Yes/No** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
13. Have you had any cavities within the past 3 years? **Yes/No** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
14. Does your mouth seem dry sometimes? **Yes/No** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
15. Are any teeth sensitive to hot, cold, sweets, or chewing? **Yes/No** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
16. Do you get food caught between any teeth? **Yes/No** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
17. Do your gums bleed when brushing or flossing? **Yes/No** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
18. Have you ever been treated for gum (periodontal) disease or had a deep cleaning? **Yes/No**\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_