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DENTAL HISTORY (adopted from Dr. John Kois)

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Poor
How long ago were you seen by a dentist last? Years ..... Months .....
Date of most recent x-rays? .....
Date of most recent treatment (other than a cleaning)? .....
I routinely saw my dentist every? ☐ 4 mo. ☐ 6 mo. ☐ >12 mo.

WHAT IS YOUR IMMEDIATE CONCERN? .....
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PLEASE, ANSWER THE FOLLOWING QUESTIONS

A. PAST EXPERIENCES		Y	N
1	Are you afraid of dental treatment? Scale 1-10 _____	❑	❑
2	Have you had negative experiences with past dental treatments?	❑	❑
3	Have you ever experienced complications with past dental treatments?	❑	❑
4	Did you ever have problems to be anesthetized or did you have adverse reactions?	❑	❑
5	Did you receive orthodontic treatment or did you have your bite corrected?	❑	❑
6	Have you had any tooth extracted?	❑	❑

B. SMILE CHARACTERISTICS		Y	N
7	Is there any thing about the appearance of your teeth that you would like to change?	❑	❑
8	Have you ever whitened (bleached) your teeth?	❑	❑
9	Have you been disappointed with the appearance of previous dental work?	❑	❑

C. BITE AND JAW JOINT		Y	N
10	Do you/would you have any problems chewing gum?	❑	❑
11	Do you/would you have any problems chewing hard foods?	❑	❑
12	Have your teeth changed in the last 5 years, become shorter, thinner or worm?	❑	❑
13	Are your teeth crowding or developing spaces?	❑	❑
14	Do you have more than one bite and squeeze to make your teeth fit together?	❑	❑
15	Do you have any problems with sleep or wake up with an awareness of your teeth?	❑	❑
16	Do you/did you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	❑	❑

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17	Do you brux, clench or squeeze your teeth in the daytime or make them sore?	❑	❑
18	Do you wear or have you ever worn a bite appliance?	❑	❑
19	Do you snore frequently?	❑	❑
20	Does it ever happen that you stop breathing when sleeping?	❑	❑
21	Do you fall asleep easily during the day?	❑	❑

D. TOOTH STRUCTURE		Y	N
22	Have you had any cavities within the past 3 years	❑	❑
23	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	❑	❑
24	Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	❑	❑
25	Have you ever broken teeth, chipped teeth, or had a tooth ache or cracked filling?	❑	❑
26	Do you avoid brushing any area of your mouth?	❑	❑
27	Do you feel or notice any holes (ie. pitting, craters) on the biting surface of your teeth?	❑	❑

E. GUMS AND BONE		Y	N
28	Have you ever been treated for gum disease or been told you have lost bone around your teeth?	❑	❑
29	Have you ever experienced gum recession?	❑	❑
30	Is there anyone with a history of periodontal disease in your family?	❑	❑
31	Do your gums bleed when brushing or flossing?	❑	❑
32	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	❑	❑
33	Have you ever noticed an unpleasant taste or odor in your mouth?	❑	❑
34	Have you experienced a burning sensation in your mouth?	❑	❑

Patient's
Signature .....Date .....

Clinician's
Signature .....Date .....