Allison O'Brien DMD

# DENTAL HISTORY

Patient Name _____

Referred by _____

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

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

**WHAT IS YOUR IMMEDIATE CONCERN?**

**PLEASE ANSWER YES OR NO TO THE FOLLOWING:** **YES** **NO**

## PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scare of 1 (least) to 10 (most) (____)_____ ☐ ☐
2. Have you had an unfavorable 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 anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?_____ ☐ ☐
6. Have you 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 odor in your mouth?_____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family?_____ ☐ ☐
11. Have you ever experienced gum recession?_____ ☐ ☐

## TOOTH STRUCTURE

12. Have you had any cavities within the past 3 years?_____ ☐ ☐
13. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?_____ ☐ ☐
14. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?_____ ☐ ☐
15. Do you have grooves or notches on your teeth near the gum line?_____ ☐ ☐
16. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?_____ ☐ ☐
17. Do you frequently get food caught between any teeth?_____ ☐ ☐

## BITE AND JAW JOINT

18. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)_____ ☐ ☐
19. Have your teeth changed in the last 5 years, become shorter, thinner or worn?_____ ☐ ☐
20. Are your teeth crowding or developing spaces?_____ ☐ ☐
21. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?_____ ☐ ☐
22. Do you clench your teeth in the daytime or nighttime?_____ ☐ ☐
23. Do you have any problems with sleep or wake up with an awareness of your teeth?_____ ☐ ☐
24. Do you wear or have you ever worn a bite appliance?_____ ☐ ☐

## SMILE CHARACTERISTICS

25. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
26. Have you ever whitened (bleached) your teeth?_____ ☐ ☐
27. Are you completely satisfied with prior dental work?_____ ☐ ☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____