**DENTAL HISTORY**

Former Dentist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last dental visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I see my dentist every □3 months □4 months □6 months □12 months □ not routinely

I would rate the condition of my mouth as? □Excellent □Good □Fair □Poor

Immediate Concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal History Yes No**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. | Have you ever had an unfavourable or a complication(s) from past dental experience? |  |  |
| 2. | Have you ever had trouble getting numb or experienced a reaction to local anesthetic? |  |  |

**Cosmetics**

|  |  |  |  |
| --- | --- | --- | --- |
| 3. | Is there anything about the appearance of your teeth that you would like to change? |  |  |
| 4. | Have you ever whitened (bleached) your teeth? If no, would you like to? □Yes □No |  |  |
| 5. | Are you self-conscious about your teeth? |  |  |
| 6. | Have you been disappointed with the appearance of previous dental work? |  |  |

**Function**

|  |  |  |  |
| --- | --- | --- | --- |
| 7. | Do you have problems chewing gum and or hard foods? |  |  |
| 8. | Have your teeth changed in the last 5 years, become shorter, thinner, worn or darker? |  |  |
| 9. | Are your teeth crowding or developing spaces? |  |  |
| 10. | Are their areas in your mouth where food gets trapped? |  |  |
| 11. | Do you bite your nails or hold foreign objects with your teeth? (i.e.: pens, pencils, nails) |  |  |
| 12. | Do you have problems with your jaw joint/TMJ? (pain, sounds, limited opening, locking, popping) |  |  |
| 13. | Do you wear a night appliance/guard or sports guard? |  |  |
| 14. | Have you ever had jaw surgery? If yes when? |  |  |
| 15. | Have you had orthodontic treatment? If yes when? |  |  |
| 16. | Do you have implants or dentures? |  |  |
| 17. | Have you had extractions? Where and When? |  |  |
| 18. | Have you had any root canals? |  |  |
| 19. | Do you clench or grind during the day or been told you do so at night? |  |  |

**Comfort**

|  |  |  |  |
| --- | --- | --- | --- |
| 20. | Have you had cavities within the past 3 years? Have you ever had a toothache? |  |  |
| 21. | Have you ever had cracked filling, and broken, chipped or cracked tooth? |  |  |
| 22. | Do you avoid brushing any part of your mouth? |  |  |
| 23. | Do you experience a burning sensation? |  |  |
| 24. | Are any of your teeth sensitive to hot, cold, sweets or pressure? |  |  |
| 25. | Do you bite your cheeks? |  |  |
| 26. | Do you breathe through your mouth? Are your lips always chapped? Do you have dry mouth? |  |  |
| 27 | At rest is your tongue on the roof of your mouth? |  |  |

**Longevity**

|  |  |  |  |
| --- | --- | --- | --- |
| 28. | Do you have or been told you have gum disease? |  |  |
| 29. | Have you had gum surgery? If yes, where and when? |  |  |
| 30. | Have your gums receded? If yes, where and when? |  |  |
| 31. | Are you teeth getting loose? |  |  |
| 32. | Do your gums bleed when brushing, flossing or eating? |  |  |
| 33. | Have you ever noticed an unpleasant taste or odour in your mouth? |  |  |
| 34. | Has anyone ever told you that you have bad breath? |  |  |
| 35. | Do your gums and or teeth hurt during cleanings? |  |  |
| 36. | Have you ever had your teeth cleaned with freezing? |  |  |
| 37. | Do you wear any oral piercings (extra or intraoral)? Have you ever? □Yes □No |  |  |
| 38. | Have you had dental work done in a country other than the U.S. or Canada? |  |  |

What is your current home care regime? Floss □Yes □No If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_ Waterpik □Yes □No If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_ Mouth rinse? □Yes □No If yes, with □Alcohol □Without Alcohol □ With Fluoride □ Without Fluoride Tooth Brush? □Manual □Electric How often? \_\_\_\_\_\_\_\_\_\_\_ Other home care products: \_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_