# CHESAPEAKE SMILES
# DENTAL HISTORY

**Patient Name** _____ **Birth Date**_____

Referred by: _____ How would you rate the condition of your mouth? ○ Excellent ○ Good ○ Fair ○ Poor
Previous Dentist: _____ How long were you a patient? _____ Month/Years
Date of Most Recent Treatment (other than a cleaning) _____/_____/_____ Date of Most Recent X-Rays _____/____/____
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

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] _____ ○ Yes ○ No
2. Have you had an unfavorable dental experience? _____ ○ Yes ○ No
3. Have you ever had complications from past dental treatment? _____ ○ Yes ○ No
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ○ Yes ○ No
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ○ Yes ○ No
6. Have you had any teeth removed? _____ ○ Yes ○ No

## SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ ○ Yes ○ No
8. Have you ever whitened (bleached) your teeth? _____ ○ Yes ○ No
9. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____ ○ Yes ○ No
10. Have you been disappointed with the appearance of previous dental work? _____ ○ Yes ○ No

## BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ○ Yes ○ No
12. Do you/would you have any problems chewing gum? _____ ○ Yes ○ No
13. Do you/would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____ ○ Yes ○ No
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ○ Yes ○ No
15. Are your teeth crowding or developing spaces? _____ ○ Yes ○ No
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ ○ Yes ○ No
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ○ Yes ○ No
18. Do you clench your teeth in the daytime or make them sore? _____ ○ Yes ○ No
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ○ Yes ○ No
20. Do you wear or have your ever worn a bite appliance? _____ ○ Yes ○ No

## TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ ○ Yes ○ No
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ○ Yes ○ No
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ○ Yes ○ No
24. Are any teeth sensitive to hold, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ○ Yes ○ No
25. Do you have grooves or notches on your teeth near the gum line? _____ ○ Yes ○ No
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ○ Yes ○ No
27. Do you get food caught between any teeth? _____ ○ Yes ○ No

## GUM AND BONE

28. Do your gums bleed when brushing or flossing? _____ ○ Yes ○ No
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ○ Yes ○ No
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ○ Yes ○ No
31. Is there anyone with a history of periodontal disease in your family? _____ ○ Yes ○ No
32. Have you ever experienced gum recession? _____ ○ Yes ○ No
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ○ Yes ○ No
34. Have you experienced a burning sensation in your mouth? _____ ○ Yes ○ No

**SIGNATURE OF PATIENT, PARENT, or GUARDIAN** _____ **DATE** _____

**SIGNATURE OF DENTIST** _____ **DATE** _____