4th Avenue Dental Centre

DENTAL HISTORY

Patient Name _____ How would you rate theconditionof yourmouth? O Excellent O Good O Fair O Poor

Referred by _____ How long have you been a patient? _____ Months / Years

Previous Dentist _____ Date of most recent x-rays ____/____/____

Date of most recent dental exam ____/____/____

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

Date of most recent treatment (other than a cleaning) ____/____/____

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	**YES/NO**
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]? _____	O O
2. Have you had an unfavorable dental experience? _____	O O
3. Have you ever had complications from past dental treatment? _____	O O
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	O O
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	O O
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? _____	O O
GUM AND BONE	**YES/NO**
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? _____	O O
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth? _____	O O
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? _____	O O
10. Is there anyone with a history of periodontal disease in your family? _____	O O
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____	O O
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? _____	O O
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth? _____	O O
TOOTH STRUCTURE	**YES/NO**
14. Have you had any cavities within the past 3 years? _____	O O
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food? _____	O O
16. Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth? _____	O O
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	O O
18. Do you have grooves or notches on your teeth near the gum line? _____	O O
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	O O
20. Do you frequently get food caught between any teeth? _____	O O
BITE AND JAW JOINT	**YES/NO**
21. Does your jaw joint ever have pain, sounds (clicking, crackling, or popping), or experience limited opening or locking? _____	O O
22. When you bite all of your back teeth together, does it feel like your lower jaw has to move backward, or is pushing back by your teeth?	O O
23. Do you ever have pain in your facial muscles, or have difficulty chewing gum, raw carrots, nuts, bagels, or other hard, dry foods? _____	O O
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____	O O
25. Are your teeth becoming more crooked, crowded, or overlapped? _____	O O
26. Are any of your teeth becoming looser or are spaces forming between your teeth? _____	O O
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better?	O O
28. Do you usually place your tongue between your teeth, use it to push against them, or bite your cheeks or lips? _____	O O
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	O O
30. Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore? _____	O O
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	O O
32. Have you ever used a bite appliance, Botox, or any medication for clenching, teeth grinding, or jaw discomfort? _____	O O
SMILE CHARACTERISTICS	**YES/NO**
33. Is there anything about the appearance of your mouth (*smile, lips, teeth, gums*) that you would like to change (*color, spaces, size, shape*)?	O O
34. Have you ever bleached (whitened) your teeth? _____	O O
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____	O O
36. Have you been disappointed with the appearance of previous dental work? _____	O O

Patient's Signature _____ Date _____