NORTH CANYON
DENTISTRY

DENTAL HISTORY

Name: _____ Nickname:_____Age: _____
Referred by _____I see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. other
How would you rate the condition of your mouth? Excellent /Good / Fair / Poor
Previous Dentist? _____ How long have you been a patient? ____ Months /Years
Date of most recent dental exam: _____ Most recent x-rays: _____Most recent treatment: _____
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 to 10	Y	N
2. Have you had an unfavorable dental experience?	Y	N
3. Have you ever had complications from past dental treatment?	Y	N
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	Y	N
5. Did you ever have braces, orthodontic treatment or have your bite adjusted?	Y	N
6. Have you had any teeth removed?	Y	N
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth the you would like to change?	Y	N
8. Have you ever whitened (bleached) your teeth?	Y	N
9. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	Y	N
10 Have you been disappointed with the appearance of previous dental work?	Y	N
BITE AND JAW JOINT		
11. Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking, popping?	Y	N
12. Do you, would you have any problems chewing gum, bagels, baguettes, protein bars or other?	Y	N
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	Y	N
14. Are your teeth crowding or developing spaces?	Y	N
15. Do you have more than one bite and squeeze to make your teeth it together?	Y	N
16. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	Y	N
17. Do you clench your teeth in the daytime or make them sore?	Y	N
18. Do you have any problems with sleep or wake up with an awareness of your teeth?	Y	N
19. Do you wear or have you ever worn a bite appliance?	Y	N
TOOTH STRUCTURE		
20. Have you had any cavities within the past 3 years?	Y	N
21. Do you frequently get food caught between any teeth?	Y	N
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing?	Y	N
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	Y	N
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	Y	N
25. Do you have grooves or notches on your teeth near the gum line?	Y	N
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filing?	Y	N
GUM AND BONE		
27. Have you experienced a burning sensation in your mouth?	Y	N
28. Do your gums bleed or are they painful when brushing or flossing?	Y	N
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	Y	N
30. Have you ever noticed an unpleasant taste or odor in your mouth?	Y	N
31. Is there anyone with a history of periodontal disease in your family?	Y	N
32. Have you ever experienced gum recession?	Y	N
33. Have you ever had any teeth loose on their own (no injury), or do you have difficulty eating?	Y	N

Date:_____

_____ _____
Patient's Signature Doctor's Signature

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