TENNESSEE RIVER DENTAL

DENTAL HISTORY

Name_____

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

Date of most recent dental exam _____/_____/_____ Most recent x-rays _____/_____/_____

Date of most recent treatment (other than cleaning) _____/_____/_____

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

Previous Dentist_____

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	**YES**	**NO**
1) Are you fearful of dental treatment?	☐	☐
2) How fearful, on a scale of 1(least) to 10(most)_____	☐	☐
3) Have you had an unfavorable dental experience?	☐	☐
4) Have you ever had complications from past dental treatment?	☐	☐
5) Have you ever had trouble getting numb?	☐	☐
6) Have you ever had any reactions to dental anesthetics?	☐	☐
7) Did you ever have braces, orthodontic treatment?	☐	☐
8) Have you ever had your bite adjusted? If so, at what age?_____	☐	☐
9) Have you ever had any teeth removed or lost teeth due to injury or facial trauma?	☐	☐
10)Do you have any missing teeth that never developed?	☐	☐
GUM AND BONE		
11)Do your gums bleed or are they painful when brushing or flossing?	☐	☐
12) Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
13)Have you ever noticed and unpleasant taste or odor in your mouth?	☐	☐
14)Is there anyone with a history of periodontal disease in your family?	☐	☐
15)Have you ever experienced gum recession?	☐	☐
16) Have you ever had any teeth become loose on their own(without an injury), Or do you have difficulty eating an apple?	☐	☐
17) Have you ever experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐

TOOTH STRUCTURE	**YES**	**NO**
18) Have you had any cavities within the past 3 years?	☐	☐
19) Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food?	☐	☐
20) Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
21) Are your teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
22) Do you have grooves or notches on your teeth near the gum line?	☐	☐
23) Have you ever broken teeth, chipped, teeth, or had a toothache or a cracked filling?	☐	☐
24) Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		
25) Do you have problems with your jaw? (pain, sounds, limited opening, locking, popping)	☐	☐
26) Do you feel like your lower jaw is being pushed back when you bite your back teeth together?	☐	☐
27) Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
28) In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
29) Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
30) Are your teeth developing spaces or becoming more loose?	☐	☐
31) Do you have trouble finding your bite, or need to squeeze, tap your teeth together or shift your jaw to make your teeth fit together?	☐	☐
32) Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
33) Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
34) Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
35) Do you have any problems with sleep(i.e. restlessness or teeth grinding) wake up with a headache or an awareness of your teeth?	☐	☐
36) Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		
37) Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?	☐	☐
38) Have you ever whitened (bleached) your teeth?	☐	☐
39) Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
40) Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature_____Date_____

Doctor's Signature_____Date_____