Dental History

Holmes FAMILY & COSMETIC DENTISTRY
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Referred by:_____ 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: _____/_____/_____ Date of most recent x-rays _____/_____/_____

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

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

WHAT IS YOUR IMMEDIATE CONCERN? _____

PERSONAL HISTORY ○○○	NO	YES
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____	○	○
2. Have you had an unfavorable dental experience?	○	○
3. Have you ever had complications from past dental treatment?	○	○
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	○	○
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	○	○
6. Have you had any teeth removed or missing teeth that never developed?	○	○
GUM AND BONE ○○○		
7. Do your gums bleed or are they painful when brushing or flossing?	○	○
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	○	○
9. Have you ever noticed an unpleasant taste or odor in your mouth?	○	○
10. Is there anyone with a history of periodontal disease in your family?	○	○
11. Have you ever experienced gum recession?	○	○
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	○	○
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	○	○
TOOTH STRUCTURE ○○○		
14. Have you had any cavities within the past 3 years?	○	○
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	○	○
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	○	○
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	○	○
18. Do you have grooves or notches on your teeth near the gum line?	○	○
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	○	○
20. Do you frequently get food caught between any teeth?	○	○
BITE AND JAW JOINT ○○○		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	○	○
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?	○	○
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	○	○
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	○	○
25. Are your teeth becoming more crooked, crowded, or overlapped?	○	○
26. Are your teeth developing spaces or becoming more loose?	○	○
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?	○	○
28. Do you place your tongue between your teeth or close your teeth against your tongue?	○	○
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	○	○
30. Do you clench your teeth in the daytime or make them sore?	○	○
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?	○	○
32. Do you wear or have you ever worn a bite appliance?	○	○
SMILE CHARACTERISTICS ○○○		
33. Is there anything about the appearance of your teeth that you would like to change?	○	○
34. Have you ever whitened (bleached) your teeth?	○	○
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	○	○
36. Have you been disappointed with the appearance of previous dental work?	○	○

Patient's Signature:_____ Date:_____

Doctor's Signature:_____ Date:_____

SUBMIT