SOUTHERN OKANAGAN
FAMILY DENTAL

DENTAL HISTORY

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PATIENT NAME _____ **PREFERRED NAME** _____ **AGE** _____

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 EXAM ____ / ____ / ____ **DATE OF MOST RECENT X-RAYS** ____ / ____ / ____

DATE OF MOST RECENT TREATMENT (OTHER THAN A CLEANING) ____ / ____ / ____

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) [____]	☐ 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 had your bite adjusted, and at what age?	☐ Y ☐ N	
6 Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma?	☐ Y ☐ N	
GUM AND BONE		
7 Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	☐ Y ☐ N	
8 Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	☐ Y ☐ N	
9 Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?	☐ Y ☐ N	
10 Is there anyone with a history of periodontal disease in your family?	☐ Y ☐ N	
11 Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐ Y ☐ N	
12 Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing?	☐ Y ☐ N	
13 Have you experienced a burning, painful sensation, or metallic taste in your mouth?	☐ Y ☐ N	
TOOTH STRUCTURE		
14 Have you had any cavities within the past 3 years?	☐ Y ☐ N	
15 Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food?	☐ Y ☐ N	
16 Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐ Y ☐ N	
17 Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐ Y ☐ N	
18 Do you have grooves or notches on your teeth near the gum line?	☐ Y ☐ N	
19 Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐ Y ☐ N	
20 Do you frequently get food caught between any teeth?	☐ Y ☐ N	
BITE AND JAW JOINT		
21 Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking?	☐ Y ☐ N	
22 Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together?	☐ Y ☐ N	
23 Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐ Y ☐ N	
24 In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐ Y ☐ N	
25 Are your teeth becoming more crooked, crowded, or overlapped?	☐ Y ☐ N	
26 Are your teeth developing spaces or becoming more loose?	☐ Y ☐ N	
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?	☐ Y ☐ N	
28 Do you place your tongue between your teeth or close your teeth against your tongue?	☐ Y ☐ N	
29 Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐ Y ☐ N	
30 Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore?	☐ Y ☐ N	
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?	☐ Y ☐ N	
32 Do you wear or have you ever worn a bite appliance?	☐ Y ☐ N	
SMILE CHARACTERISTICS		
33 Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)?	☐ Y ☐ N	
34 Have you ever bleached (whitened) your teeth?	☐ Y ☐ N	
35 Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐ Y ☐ N	
36 Have you been disappointed with the appearance of previous dental work?	☐ Y ☐ N	

Patient's Signature _____ Date _____ Dentist's Signature _____ Date _____