DePalma Dental

DENTAL HISTORY

Name: ____________________________ Date of Birth: ____________ 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 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE CIRCLE YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

Are you fearful of dental treatment? If yes, how fearful, on a scale of 1 (least) to 10 (most)? _________ YES / NO

Have you had an unfavorable dental experience? ____ YES / NO

Have you ever had complications from past dental treatment? __________________________________ YES / NO

Have you ever had trouble getting numb or had any reactions to local anesthetic? __________________ YES / NO

Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _________ YES / NO

Have you had any teeth removed or missing that never developed or lost teeth due to injury/facial trauma? YES / NO

GUM AND BONE

Do your gums bleed or are they painful when brushing or flossing? _______________________________ YES / NO

Have you ever been treated for gum disease or been told you have lost bone around your teeth? ________ YES / NO

Have you ever noticed an unpleasant taste or odor in your mouth? ________________________________ YES / NO

Is there anyone with a history of periodontal disease in your family? _______________________________ YES / NO

Have you ever experienced gum recession? ____ YES / NO

Have you had any teeth become loose on their own (without injury), or do you have difficulty eating an apple? YES / NO

Have you experienced a burning or painful sensation in your mouth not related to your teeth? __________ YES / NO

TOOTH STRUCTURE

Have you had any cavities within the past 3 years? ____ YES / NO

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? YES / NO

Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ________________ YES / NO

Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? YES / NO

Do you have grooves or notches on your teeth near the gum line? _________________________________ YES / NO

Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ____________________ YES / NO

Do you frequently get food caught between any teeth? ____ YES / NO

BITE AND JAW JOINT

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)___________ YES / NO

Do you feel like your lower jaw is being pushed back when you bite your back teeth together? _________ YES / NO

Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, protein bars, or other hard, dry foods? YES / NO

In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed? YES / NO

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Are your teeth becoming more crooked, crowded, or overlapped? _______________________________ YES / NO

Are your teeth developing spaces, or becoming more loose? ___________________________________ YES / NO

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? ____ YES / NO

Do you place your tongue between your teeth or close your teeth against your tongue? ______________ YES / NO

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ________ YES / NO

Do you clench or grind your teeth together in the daytime or make them sore? _____________________ YES / NO

Do you have any problems with sleep (i.e. restlessness or grinding) wake up with a headache or tooth pain? YES / NO

Do you wear or have you ever worn a bite appliance? ____ YES / NO

SMILE CHARACTERISTICS

Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? YES / NO

Have you ever whitened (bleached) your teeth? ____ YES / NO

Have you felt uncomfortable or self conscious about the appearance of your teeth? __________________ YES / NO

Have you been disappointed with the appearance of previous dental work? ________________________ YES / NO

Patient's Signature ____ Date ______________________

Doctor's Signature ____ Date ______________________