DENTAL HISTORY

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

Previous Dentist_____How long had you been a patient? _____

Date of most recent dental exam_____ Date of most recent x-rays (if known) _____

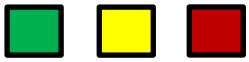
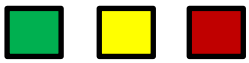
Date of most recent dental treatment (other than cleaning) _____

I routinely see my dentist every □ 6 months □12 months □Not routinely

What is your immediate concern? _____

_____

_____

Please answer YES or NO to the following with a tick	YES	NO
DENTAL EXPERIENCE 		
Are you fearful of dental treatment? How fearful, on a scale of 1(least) 10(most) _____	___	___
Have you had an unfavourable experience or complications _____	___	___
Have you ever had trouble getting numb or reactions to local anaesthetic? _____	___	___
Did you ever had braces, orthodontic treatment or had your bite adjusted? _____	___	___
Have you had any teeth removed? _____	___	___
Aesthetic 		
Is there anything about the appearance of your teeth you would like to change? _____	___	___
Have you ever whitened (bleached) your teeth? _____	___	___
Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____	___	___
Have you been disappointed with the appearance of previous dental work? _____	___	___
Occlusion/TMJ 		
The way your teeth meet and glide against each other		
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	___	___
Do you suffer with headaches, neck- and/or neck pain?	___	___
Do you/would you have any problems chewing gum, baguettes or hard food? _____	___	___
Have your teeth changed in the last 5 years become shorter, thinner or worn? _____	___	___
Are your teeth crowding or developing spaces? _____	___	___
Do you have more than one bite and/or squeeze to make your teeth fit together? _____	___	___
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	___	___
Do you clench your teeth in the day/night time? _____	___	___
Do you have any problems with sleep, sleep apnoea or wake up aware of your teeth? _____	___	___

Do you wear or have you ever worn a bite appliance? _____ ___ ___

Tooth Structure

Have you had any cavities in the last 3 years? _____ ___ ___

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food? _____ ___ ___

Do you feel or notice any holes (i.e. pitting craters) on the biting surface of your teeth? _____ ___ ___

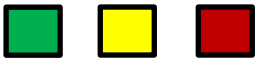
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing part of your mouth? _____ ___ ___

Do you have grooves or notches on your teeth near the gum line? _____ ___ ___

Have you ever broken teeth, chipped teeth, or had toothache or cracked fillings? _____ ___ ___

Do you get food caught between any teeth? _____ ___ ___

Please answer YES or NO to the following with a tick **YES** **NO**



Periodontal

Do your gums bleed when brushing, flossing or eating? _____ ___ ___

Have you ever been treated for gum disease or told you have lost bone around your teeth? _____ ___ ___

Have you ever noticed an unpleasant taste or odour in your mouth? _____ ___ ___

Is there anyone with a history of periodontal/gum disease in your family? _____ ___ ___

Have you ever experienced gum recession? _____ ___ ___

Have you ever had any teeth become loose/problems biting hard foods? _____ ___ ___

Patient Signature _____ Date _____