CONFIDENTIAL DENTAL HISTORY

Patient's Name: _____

Previous Dentist: _____ How Long? _____

Last Dental Visit: _____ Last Dental X-rays _____

How often do you have your teeth cleaned? ☐ 3mo. ☐ 4 mo. ☐ 6 mo. ☐ 1year or longer

Why did you leave your last dentist? _____

What is your immediate dental concern? _____

How often do you brush? _____ floss? _____

Do you use any devices other than a manual brush and floss? ☐ yes ☐ no If yes what _ _____

Please √ YES or NO to each question. If unsure of a question, please consult with the dentist.

		YES	NO	DENTIST'S NOTES
1.	unhappy with the appearance of your teeth?_____	☐	☐	_____
2.	unfavourable dental experiences? _____	☐	☐	_____
3.	dental fears? _____	☐	☐	_____
4.	problems with effectiveness or bad reactions to dental anaesthetic?	☐	☐	_____
5.	orthodontic treatment (braces)? When_____	☐	☐	_____
6.	periodontal (gum) treatment _____	☐	☐	_____
7.	bleeding, pain or swelling from gums? _____	☐	☐	_____
8.	loose or shifted teeth? _____	☐	☐	_____
9.	food traps between teeth? _____	☐	☐	_____
10.	growths or sore spots in your mouth? _____	☐	☐	_____
11.	teeth sensitive to heat, cold, sweets? _____	☐	☐	_____
12.	teeth sensitive to pressure? _____	☐	☐	_____
13.	avoid brushing any part of your mouth? _____	☐	☐	_____
14.	a burning sensation in your mouth? _____	☐	☐	_____
15.	difficulty swallowing? _____	☐	☐	_____
16.	unpleasant taste or odour in your mouth? _____	☐	☐	_____
17.	dry mouth? _____	☐	☐	_____
18.	jaw problems (temporomandibular joint)? _____	☐	☐	_____
19.	difficulty opening your mouth widely? _____	☐	☐	_____
20.	stiff neck muscles? _____	☐	☐	_____
21.	awaken with an awareness of your teeth and jaws? _____	☐	☐	_____
22.	tension headaches? _____	☐	☐	_____
23.	clench your teeth? _____	☐	☐	_____
24.	grind your teeth? _____	☐	☐	_____
25.	jaw clicking or popping? _____	☐	☐	_____
26.	do you wear a nightguard? _____	☐	☐	_____
27.	would you like your teeth to be whiter? _____	☐	☐	_____

What do you like or dislike (or both) about your smile? _____
_____

How nervous are you about dental treatment on a scale. (Circle one) [1 2 3 4 5] 1=not at all, 5= extremely nervous

SUPPLEMENTAL DENTURE/PARTIAL DENTURE HISTORY

(if you are wearing a partial or complete artificial denture please complete the following)

	YES	NO	
Has your present denture/partial been relined?_____	☐	☐	When? _____
Is your present denture/partial a problem?_____	☐	☐	Describe:_____
Satisfied with the appearance? _____	☐	☐	
Satisfied with the comfort? _____	☐	☐	
Satisfied with the chewing ability? _____	☐	☐	

When did you receive your first partial or complete denture? _____

How long have you worn your present denture? _____

RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my dental history. I understand that information provided from or to any other dental health care providers may be necessary, and I consent to the release of this information.

Signature _____Date _____
(Patient or Guardian)

Reviewed by Treating Dentist _____ Date _____