Glenmore Park Dental
Dental History

Name_____________________________
How would you rate the condition of your mouth? [ ] Excellent [ ] Good [ ] Fair [ ] Poor
Previous dentist ___________________
How long were you 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? ____

Please answer yes or no to the following:	**Yes**	**No**
<u>Personal History</u>		
1) Are you fearful of dental treatment?	[ ]	[ ]
2) How fearful on a scale of 1 (least) to 10 (most) ________		
3) Have you had an unfavourable past dental treatment?	[ ]	[ ]
4) Have you ever had complications from past dental treatment?	[ ]	[ ]
5) Have you ever had trouble getting numb or had any reactions to local anaesthetic?	[ ]	[ ]
6) Did you ever have braces, orthodontic treatment or had your bite adjusted?	[ ]	[ ]
7) Have you had any teeth removed?	[ ]	[ ]
<u>Gum and Bone</u>		
8) Do your gums bleed or are they painful when brushing or flossing?	[ ]	[ ]
9) Have you ever been treated for gum disease or been told that you have lost bone around your teeth?	[ ]	[ ]
10) Have you ever noticed an unpleasant taste or odor in your mouth?	[ ]	[ ]
11) Is there anyone in your family with a history of periodontal disease?	[ ]	[ ]
12) Have you ever experienced gum recession?	[ ]	[ ]
13) Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	[ ]	[ ]
14) Have you experienced a burning sensation in your mouth?	[ ]	[ ]
<u>Tooth Structure</u>		
15) Have you had any cavities within the past 3 years?	[ ]	[ ]
16) Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	[ ]	[ ]
17) Do you feel or notice any holes on the biting surface of your teeth?	[ ]	[ ]
18) Are any teeth sensitive to hot, cold, biting, sweets or do you avoid brushing any part of your mouth? (Underline all that apply.)	[ ]	[ ]
19) Do you have grooves or notches on your teeth near the gumline?	[ ]	[ ]
20) Have you ever broken teeth, chipped teeth, or cracked a filling?	[ ]	[ ]
21) Do you frequently get food caught between any teeth?	[ ]	[ ]

	Yes	No
Bite and Jaw Joint		
22) Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) (Underline all that apply.)	[ ]	[ ]
23) Do you feel like your lower jaw is being pushed back when you bite your teeth together?	[ ]	[ ]
24) Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	[ ]	[ ]
25) Have your teeth changed in the last 5 years, become shorter, thinner or worn?	[ ]	[ ]
26) Are your teeth becoming more crooked, crowded, or overlapped?	[ ]	[ ]
27) Are your teeth developing spaces or becoming more loose?	[ ]	[ ]
28) Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?	[ ]	[ ]
29) Do you place your tongue between your teeth or close you teeth against your tongue?	[ ]	[ ]
30) Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	[ ]	[ ]
31) Do you clench your teeth in the daytime or make them sore?	[ ]	[ ]
32) Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?	[ ]	[ ]
33) Do you wear or have you ever worn a bite appliance?	[ ]	[ ]
Smile Characteristics		
34) Is there anything about the appearance of your teeth that you would like to change?	[ ]	[ ]
35) Have you ever whitened (bleached) your teeth?	[ ]	[ ]
36) Have you felt uncomfortable or self-conscious about the appearance of your teeth?	[ ]	[ ]
37) Have you been disappointed with the appearance of previous dental work?	[ ]	[ ]

Patient's signature ____**Date** __________

Dentist's signature ____**Date** __________