Global Smiles - Dental History

Name ________________________________ Nickname __________________ Age _________

Referred by _______________________

How would you rate the condition of you mouth? (please circle) Excellent Good Fair

Previous Dentist _________________________ How long have you been patient? ___________

Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____

Date or most recent treatment (other than a cleaning) ____/____/____

I routinely see my debits every: (please circle) 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

What is your Immediate concern? ____

Please answer Yes or No to the following questions:

PERSONAL HISTORY	Yes	No
Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most).	1-10	n/a
Have you had an unfavorable dental experience?	Y	N
Have you ever had complications from past dental treatment?	Y	N
Have you ever had trouble getting numb or had any reactions to local anesthetic?	Y	N
Did you ever have braces, orthodontic treatment or had your bite adjusted?	Y	N
Have you had any teeth removed?	Y	N

SMILE CHARACTERISTICS	Yes	No
Is there anything about the appearance of your teeth that you would like to change?	Y	N
Have you ever whitened (bleached) your teeth?	Y	N
Have you felt uncomfortable or self conscious about the appearance of your teeth?	Y	N
Have you been disappointed with the appearance of previous dental work?	Y	N

BITE & JAW JOINT	Yes	No
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	Y	N
Do you/would you have any problems chewing gum?	Y	N
Do you have any problems chewing? (bagels, baguettes, protein bars, other hard foods)	Y	N
Have your teeth changed in the last 5 years, become shorter, thinner or worm?	Y	N
Are your teeth crowding or developing spaces?	Y	N

Do you have more than one bite and squeeze to make your teeth fit together?	Y	N
Do you chew ice, bite your nails, use your teeth to hold objects, or any other oral habits?	Y	N
Do you clench your teeth in the daytime or make them sore?	Y	N
Do you have any problems with sleep or wake up with an awareness of your teeth?	Y	N
Do you wear or have you ever worn a bite appliance?	Y	N

TOOTH STRUCTURE	Yes	No
Have you had any cavities within the past 3 years?	Y	N
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	Y	N
Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	Y	N
Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing part of your mouth?	Y	N
Do you have grooves or notches on your teeth near the gum line?	Y	N
Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	Y	N
Do you frequently get food caught between any teeth?	Y	N

GUM & BONE	Yes	No
Do your gums bleed or are they painful when brushing or flossing?	Y	N
Have you ever been treated for gum disease or been told you have lost bone around your teeth?	Y	N
Have you ever noticed an unpleasant taste or odor in your mouth?	Y	N
Is there anyone with a history of periodontal disease in your family?	Y	N
Have you ever experienced gum recession?	Y	N
Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	Y	N
Have you experience a burning sensation in your mouth?	Y	N

Patient’s Signature ____

Doctor’s Signature ____