Cranston 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**
Personal History		
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?	☐	☐
Gum and Bone		
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?	☐	☐
Tooth Structure		
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** _____