Dental History

Muscaro & Martini Dentistry
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Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ○ Excellent ○ Good ○ Fair ○ Poor

Previous Dentist _____ How long have you been a patient? _____ Months / Years

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

Date of most recent treatment (other than 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? How fearful, on a scale of 1 (least) to 10 (most)	○	○
2. Have you had an unfavorable dental experience?	○	○
3. Have you ever had complications from past dental treatment?	○	○
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	○	○
5. Have you ever had braces, orthodontic treatment or your bite adjusted?	○	○
6. Have you had any teeth removed?	○	○
Smile Characteristics		
7. Is there anything about the appearance of your teeth that you would like to change?	○	○
8. Have you ever whitened (bleached) your teeth?	○	○
9. Have you felt uncomfortable or self conscious about the appearance of your teeth?	○	○
10. Have you been disappointed with the appearance of previous dental work?	○	○
Bite and Jaw Joint		
11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	○	○
12. Do you / would you have any problems chewing gum?	○	○
13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods?	○	○
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	○	○
15. Are your teeth crowding or developing spaces?	○	○
16. Do you have to squeeze to make your teeth fit together or do you have more than one bite?	○	○
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	○	○
18. Do you clench your teeth in the daytime or make them sore?	○	○
19. Do you have any problems with sleep or wake up with an awareness of your teeth?	○	○
20. Do you wear or have you ever worn a bite appliance?	○	○
Tooth Structure		
21. Have you had any cavities within the past 3 years?	○	○
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	○	○
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	○	○
24. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	○	○
25. Do you have grooves or notches on your teeth near the gum line?	○	○
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	○	○
27. Do you get food caught between any teeth?	○	○
Gum and Bone		
28. Do your gums bleed when brushing or flossing?	○	○
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	○	○
30. Have you ever noticed an unpleasant taste or odor in your mouth?	○	○
31. Is there anyone with a history of periodontal disease in your family?	○	○
32. Have you ever experienced gum recession?	○	○
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	○	○
34. Have you experienced a burning sensation in your mouth?	○	○

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____