DENTAL HISTORY

THREE RIVERS DENTAL
EVON HEASER DDS

Name: _____

How would you rate the condition of your mouth? □ Excellent □ Good □ Fair □ Poor
Previous Dentist _____
I routinely see my dentist every □ 3 mo. □ 4 mo. □ 6 mo. □ 12 mo. □ Not routinely
WHAT IS YOUR IMMEDIATE CONCERN? _____

_____

	PERSONAL HISTORY	YES	NO
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.	Did you ever have braces, orthodontic treatment or had your bite adjusted? At what age? _____	□	□
6.	Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	□	□
	GUM AND BONE		
7.	Do your gums bleed or are they painful when brushing or flossing?	□	□
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth?	□	□
9.	Have you ever noticed an unpleasant taste or odor in your mouth?	□	□
10.	Is there anyone with a history of periodontal disease in your family?	□	□
11.	Have you ever experienced gum recession?	□	□
12.	Have you ever had any teeth become loose on their own (w/out an injury), or do you have difficulty eating an apple?	□	□
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth?	□	□
	TOOTH STRUCTURE		
14.	Have you had any cavities within the past 3 years?	□	□
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	□	□
16.	Do you feel or notice any holes (ie: pitting, craters) on the biting surface of your teeth?	□	□
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	□	□
18.	Do you have grooves or notches on your teeth near the gum line?	□	□
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	□	□
20.	Do you frequently get food caught between any teeth?	□	□
	BITE AND JAW JOINT		
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	□	□
22.	Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	□	□
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	□	□
24.	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite change?	□	□
25.	Are your teeth becoming more crooked, crowded, or overlapped?	□	□
26.	Are your teeth developing spaces or becoming more loose?	□	□
27.	Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	□	□
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	□	□
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	□	□
30.	Do you clench or grind your teeth together in the daytime or make them sore?	□	□
31.	Do you have any problems with sleep (ie: restlessness/teeth grinding), wake up with a headache or an awareness of your teeth?	□	□
32.	Do you wear or have you ever worn a bite appliance?	□	□
	SMILE CHARACTERISTICS		
33.	Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?	□	□
34.	Have you ever whitened (bleached) your teeth?	□	□
35.	Have you felt uncomfortable or self-conscious about the appearance of your teeth?	□	□
36.	Have you been disappointed with the appearance of previous dental work?	□	□

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____