Dental History

Name: _____

What is the most important thing to you about your visit today? _____

Date of most recent dental visit other than a cleaning _____

I routinely see my dentist every: 3mos 6mos 12mos Not routinely

What is the most important thing to you about your future smile and dental health? _____

On a scale of 1 to 10, with 10 being the highest rating...

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
How fearful of dental treatment are you?	1	2	3	4	5	6	7	8	9	10

Personal History

	Yes	No
Have you ever had an unfavourable dental experience?	☐	☐
Have you ever had complications from past dental treatment?	☐	☐
Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
Have you had any teeth removed?	☐	☐

Smile Characteristics

Is there anything about the appearance of your teeth that you would like to change?	☐	☐
Have you ever whitened your teeth?	☐	☐
Are you self conscious about your teeth?	☐	☐
Have you ever been disappointed with the appearance of previous dental work?	☐	☐

Bite and Jaw Joint

Do you have any problems chewing gum?	☐	☐
Do you have any problems chewing bagels or other hard foods?	☐	☐
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
Are your teeth crowding or developing spaces?	☐	☐
Do you have to clench to make your teeth fit together?	☐	☐
Do you wake up feeling like you have been clenching or grinding your teeth?	☐	☐
Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)?	☐	☐
Do you have tension headaches or sore teeth?	☐	☐
Do you wear or have you ever worn a bite appliance?	☐	☐

Tooth Structure

Have you had any cavities within the past 3 years?	☐	☐
Do you have a dry mouth?	☐	☐
Are any teeth sensitive to hot, cold, biting or sweets?	☐	☐
Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?	☐	☐
Do you avoid brushing any part of your mouth?	☐	☐

Gum and Bone

Have you ever been diagnosed or treated for periodontal (gum) disease?	☐	☐
Have you ever experienced gum recession?	☐	☐
Is there anyone with a history of periodontal disease in your family?	☐	☐
Do your gums bleed when brushing, flossing, eating?	☐	☐
Are your teeth becoming loose?	☐	☐
Have you ever noticed an unpleasant taste or odour in your mouth?	☐	☐
Have you experienced a burning sensation in your mouth?	☐	☐

DAWSON DENTAL CENTRE