Julie A. Fattore, DDS

DENTAL HISTORY

Patient Name _____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist _____ How long had you been a patient? _____

Date of most recent dental exam _____ Date of most recent dental cleaning _____

Date of most recent x-rays _____

I saw my previoius dentist every: 3 mo. 4mo. 6mo. 12mo. Not routinely (circle one)

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	Yes	No
1. Are your fearful of dental treatment? Scale of 1 to 10 (very) _____		
2. Have you had an unfavorable dental experience? _____		
3. Have you had complications from past dental treatment? _____		
4. Have you ever had trouble getting numb or reactions to local anesthetics ? _____		
5. Did you have braces, orthodontic treatment or had your bite adjusted? _____		
6. Have you had any teeth removed? _____		
BITE AND JAW JOINT		
7. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____		
8. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____		
9. Are your teeth crowding or developing spaces? _____		
10. Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits? _____		
11. Do you clench your teeth in the daytime or make them sore? _____		
12. Do you have tension headaches or sore teeth? _____		
13. Do you wear or have you ever worn a bite appliance? _____		
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years? _____		
15. Does the saliva in your mouth seem too little? Do you have difficulty swallowing any food? _____		
16. Are any teeth sensitive to hot, cold, biting or sweets? _____		
17. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____		
18. Do you frequently get food caught between any teeth? _____		
19. Do you avoid brushing any part of your mouth? _____		
GUM AND BONE		
20. Do your gums bleed or is it painful when brushing or flossing? _____		
21. Have you ever been treated for periodontal (gum) disease or told you have lost bone around your teeth? _____		
22. Have you ever noticed an unpleasant taste or odor in your mouth? _____		
23. Are any teeth becoming loose? _____		
24. Does anyone in your family have a history of periodontal disease? _____		
25. Have you ever experienced gum recession? _____		
SMILE CHARACTERISTICS		
26. Have you ever whitened (bleached) your teeth? _____		
27. Have you ever felt uncomfortable or self-conscious about the appearance of your teeth and gums? _____		
28. Have you ever been disappointed with the appearance of previous dental work? _____		
29. Is there anything about your smile you would like to change? _____		
30. Do you have any other concerns? _____		

Patient Signature _____ Date _____

Doctor Signature _____ Date _____