TOWN CENTRE
DENTAL CLINIC

DENTAL HISTORY

Patient Name: _____Former Dentist Name: _____

I see my dentist every □3 □4 □6 □12 months □not routinely. Last dental visit: _____

I would rate the condition of my mouth as? □Excellent □Good □Fair □Poor

Immediate Concern: _____

Personal History		**Yes**	**No**
1.	Have you ever had an unfavourable or a complication(s) from past dental experience?		
2.	Have you ever had trouble getting numb or experienced a reaction to local anesthetic?		

Cosmetics

3.	Is there anything about the appearance of your teeth that you would like to change?		
4.	Have you ever whitened (bleached) your teeth?		
5.	Are you interested in Whitening, Veneers, Crowns, Invisalign, Braces, White fillings?		
6.	Are you self-conscious about your teeth?		
7.	Have you been disappointed with the appearance of previous dental work?		

Function

8.	Do you have problems chewing gum and/or hard foods?		
9.	Have your teeth changed in the last 5 years, become shorter, thinner, worn or darker?		
10.	Are your teeth crowding or developing spaces?		
11.	Are there areas in your mouth where food gets trapped?		
12.	Do you bite your nails or hold foreign objects with your teeth? (i.e. pens, pencils, nails)		
13.	Do you have problems with your jaw joint/TMJ? (pain, sounds, limited opening, locking, popping)		
14.	Do you wear or have you worn a night appliance/guard or sports guard?		
15.	Have you ever had jaw surgery? If yes, when?		
16.	Have you had orthodontic treatment? If yes, when?		
17.	Do you have implants or dentures?		
18.	Have you had extractions? Where and When?		
19.	Have you had any root canals?		
20.	Do you clench or grind during the day or been told you do so at night?		

Comfort

21.	Have you had cavities within the past 3 years? Have you ever had a toothache?		
22.	Have you ever had cracked fillings, and broken, chipped or cracked teeth?		
23.	Do you have tension headaches or sore teeth?		
24.	Do you experience a burning sensation in your mouth?		
25.	Are any of your teeth sensitive to hot, cold, sweets or pressure?		
26.	Do you bite your cheeks?		
27.	Do you breathe through your mouth? Are your lips always chapped? Do you have dry mouth?		
28	At rest is your tongue on the roof of your mouth?		

Longevity

29.	Do you have or been told you have gum disease?		
30.	Have you lost teeth due to gum disease? If yes, where and when?		
31.	Have you had gum surgery? If yes, where and when?		
32.	Have your gums receded? If yes, where and when?		
33.	Are your teeth getting loose?		
34.	Do your gums bleed when brushing, flossing or eating?		
35.	Have you ever noticed an unpleasant taste or odour in your mouth?		
36.	Has anyone ever told you that you have bad breath?		
37.	Do your gums and or teeth hurt during cleanings?		
38.	Have you ever had your teeth cleaned with freezing?		
39.	Do you wear any oral piercings (extra or intraoral)? Have you ever? □Yes □No		
40.	Have you had dental work done in a country other than the U.S. or Canada?		

What is your current home care regime?

Floss □Yes □No If yes, how often? _____ Waterpik □Yes □No If yes, how often? _____

Mouth rinse? □Yes □No If yes, with □Alcohol □Without Alcohol □With Fluoride □ Without Fluoride

Tooth Brush? □Manual □Electric How often? _____ Other home care products: _____

Date: _____ Patient Signature: _____