



Dental Care on Golf Links  
8975 E. Golf Links Rd  
Tucson AZ, 85730

# Dental History

Name \_\_\_\_\_ How would you rate your mouth?  Excellent  Good  Fair  Poor

Previous Dentist \_\_\_\_\_ I routinely see my dentist every:  3 mo.  4 mo.  6 mo.  12 mo.

Date of most recent dental exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of most recent x-rays \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of most recent treatment (other than a cleaning) \_\_\_\_/\_\_\_\_/\_\_\_\_

WHAT IS YOUR MOST IMMEDIATE CONCERN? \_\_\_\_\_

**PLEASE ANSWER YES OR NO TO THE FOLLOWING:**

**YES NO**

**PERSONAL HISTORY**

1. Are you fearful of dental treatment? How fearful, 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?
6. Have you had any teeth removed?

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**GUM AND BONE**

7. Do your gums bleed or are they painful when brushing or flossing?
8. Have you ever been treatment 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 (without any injury), or do you have difficulty eating an apple?
13. Have you experienced a burning sensation in your mouth?

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**TOOTH STRUCTURE**

14. Have you had any cavities in the past 3 years?
15. Does the amount of saliva in your mouth seem too little or do you have any difficulty swallowing food?
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?
18. Do you have grooves or notches on your teeth near the gumline?
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?

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**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 bite your teeth together?
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, protein bars, or other hard, dry foods?
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?
25. Are your teeth becoming more crooked, crowded, or overlapped??
26. Are your teeth developing spaces or becoming more loose?
27. Do you ever bite, squeeze, 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 your teeth in the daytime or make them sore?
31. Do you have problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?
32. Do you wear or have you ever worn a bite appliance?

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**SMILE CHARACTERISTICS**

33. Is there anything about the appearance of your teeth that you would like to change?
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?

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Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_