Dental History Interview Questionnaire

Name_____ Nickname_____ Age_____ Referred by_____

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

Previous Dentist_____ How long had you been a patient?_____ (months/years)

Date of most recent dental exam_____/_____/_____ Date of most recent x-rays_____/_____/_____

Date of most recent dental treatment (not a cleaning)_____/_____/_____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN?_____

Personal History

1. Can you describe your past dental experiences?_____

_____

_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
2. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [ ] _____	☐	☐
3. Have you had an unfavorable dental experience?_____	☐	☐
4. Have you had complications from past dental treatment?_____	☐	☐
5. Have you ever had any trouble getting numb or had any reactions to local anesthetic?_____	☐	☐
6. Did you ever have braces, other orthodontic treatment, or have your bite adjusted?_____	☐	☐
7. Have you had any teeth removed or missing teeth that never developed?_____	☐	☐
8. Is your home water supply fluoridated?_____	☐	☐
9. Do you drink bottled water, energy drinks, or sports drinks?_____	☐	☐

If yes, how often? ☐ Daily ☐ Weekly ☐ Occasionally

Gum & Bone

10. Do your gums bleed or are they painful when brushing or flossing?_____	☐	☐
11. Have you ever been treated for gum disease or been told that you have lost bone around your teeth?_____	☐	☐
12. Have you ever noticed an unpleasant taste or odor in your mouth?_____	☐	☐
13. Is there anyone in your family with a history of periodontal disease?_____	☐	☐
14. Have you ever experienced gum recession?_____	☐	☐
15. Have you ever had any teeth become loose on their own (without injury) or do you have difficulty eating an apple?_____	☐	☐
16. Have you experienced a burning or painful sensation in your mouth not related to your teeth?_____	☐	☐

Tooth Structure

	YES	NO
17. Have you had any cavities filled in the last three (3) years?_____	☐	☐
18. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food?_____	☐	☐
19. Do you feel or notice any holes (i.e. pitting, craters) on the biting surfaces of your teeth?_____	☐	☐
20. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?_____	☐	☐
21. Do you have any grooves or notches on your teeth near the gumline?_____	☐	☐
22. Have you ever broken or chipped teeth, had a toothache, or a cracked filling?_____	☐	☐
23. Do you frequently get food caught between any teeth?_____	☐	☐

Bite & Jaw Joint

24. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)_____	☐	☐
25. Do you feel like your lower jaw is being pushed back when you bite your teeth together?_____	☐	☐
26. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, or other hard, dry foods?_____	☐	☐
27. Have your teeth changed in the last 5-10 years, becoming shorter, thinner, worn, or chipped?_____	☐	☐
28. Are your teeth becoming more crooked, crowded, or overlapped?_____	☐	☐
29. Are your teeth developing spaces or becoming more loose?_____	☐	☐
30. Do you have more than one “bite”, or do you squeeze or shift your jaw to make your teeth fit together?_____	☐	☐
31. Do you place your tongue between your teeth or close your teeth against your tongue?_____	☐	☐
32. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?_____	☐	☐
33. Do you clench your teeth in the daytime or make them sore?_____	☐	☐
34. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?_____	☐	☐
35. Do you wear or have you ever worn a bite appliance or nightguard?_____	☐	☐

Smile, Esthetics, & Outlook

36. Is there anything about the appearance of your teeth that you would like to change?_____	☐	☐
_____		
37. Have you ever whitened (bleached) your teeth?_____	☐	☐
38. Have you felt uncomfortable or self-conscious about the appearance of your teeth or smile?_____	☐	☐
39. Have you been disappointed with the appearance of previous dental work?_____	☐	☐
40. Is it important for you to keep your teeth for a lifetime?_____	☐	☐
41. Have you thought about how you want your teeth to look/feel/function as you get older?_____	☐	☐
_____		
42. What would you like us to know about you that will help us work better together?_____		
_____		