Thomas J. Gilbert, DDS

DENTAL HISTORY

Patient Name_____ Date _____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist: _____ City, State_____ How long had you been a patient? _____
Date of last dental exam: _____ Date of last dental cleaning: _____Date of last x-rays: _____
I saw my previous dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely (circle one)

WHAT IS YOUR MOST IMMEDIATE CONCERN? _____

PERSONAL HISTORY

		Y	N
1.	Are you fearful of dental treatment? Scale of 1 (low) 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 betting numb or had 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

1.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking ,popping)	☐	☐
2.	Have your teeth changed in the last 5 years? (become shorter, thinner or worn)	☐	☐
3.	Are your teeth crowding or developing spaces?	☐	☐
4.	Do you chew ice, bite your nails, use your teeth to hold objects?	☐	☐
5.	Do you clench your teeth in the daytime or make them sore?	☐	☐
6.	Do you have tension headaches or sore teeth?	☐	☐
7.	Do you wear or have you ever worn a bite appliance?	☐	☐

TOOTH STRUCTURE

1.	Have you had any cavities within the past 3 years?	☐	☐
2.	Does the saliva in your mouth seem too little? Do you have difficulty swallowing any food?	☐	☐
3.	Are any teeth sensitive to hot ,cold, biting or sweets?	☐	☐
4.	Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?	☐	☐
5.	Do you frequently get food caught between any teeth?	☐	☐
6.	Do you avoid brushing any part of your mouth?	☐	☐

GUM AND BONE

1.	Do your gums bleed or is it painful when brushing or flossing?	☐	☐
2.	Have you ever been treated for periodontal disease or told you have lost bone around your teeth?	☐	☐
3.	Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
4.	Are any teeth becoming loose?	☐	☐
5.	Does anyone in your family have a history of periodontal disease?	☐	☐
6.	Have you ever experienced gum recession?	☐	☐

SMILE CHARACTERISTICS

1.	Have you ever whitened (bleached) your teeth?	☐	☐
2.	Have you ever felt uncomfortable or self-conscious about the appearance of your teeth and gums?	☐	☐
3.	Have you ever been disappointed with the appearance of previous dental work?	☐	☐
4.	Is there anything about your smile you would like to change?	☐	☐
5.	Do you have other concerns? _____		

_____

PATIENT SIGNATURE_____DATE_____