ALMA DENTAL CENTRE

DENTAL HISTORY

Patient Name: _____Former Dentist Name: _____

Last dental visit: _____ I see my dentist every □3M's □4M's □6M's □12M's □ not routinely

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

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: _____ 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? If no, would you like to? □Yes □No		
5.	Are you self-conscious about your teeth?		
6.	Have you been disappointed with the appearance of previous dental work?		
Function			
7.	Do you have problems chewing gum and/or hard foods?		
8.	Have your teeth changed in the last 5 years, become shorter, thinner, worn or darker?		
9.	Are your teeth crowding or developing spaces?		
10.	Are there areas in your mouth where food gets trapped?		
11.	Do you bite your nails or hold foreign objects with your teeth? (i.e.: pens, pencils, nails)		
12.	Do you have problems with your jaw joint/TMJ? (pain, sounds, limited opening, locking, popping)		
13.	Do you wear a night appliance/guard or sports guard?		
14.	Have you ever had jaw surgery? If yes, when?		
15.	Have you had orthodontic treatment? If yes, when?		
16.	Do you have implants or dentures?		
17.	Have you had extractions? Where and When?		
18.	Have you had any root canals?		
19.	Do you clench or grind during the day or been told you do so at night?		
Comfort			
20.	Have you had cavities within the past 3 years? Have you ever had a toothache?		
21.	Have you ever had cracked fillings, and broken, chipped or cracked teeth?		
22.	Do you avoid brushing any part of your mouth?		
23.	Do you experience a burning sensation in your mouth?		
24.	Are any of your teeth sensitive to hot, cold, sweets or pressure?		
25.	Do you bite your cheeks?		
26.	Do you breathe through your mouth? Are your lips always chapped? Do you have dry mouth?		
27	At rest is your tongue on the roof of your mouth?		
Longevity			
28.	Do you have or been told you have gum disease?		
29.	Have you had gum surgery? If yes, where and when?		
30.	Have your gums receded? If yes, where and when?		
31.	Are any of your teeth getting loose?		
32.	Do your gums bleed when brushing, flossing or eating?		
33.	Have you ever noticed an unpleasant taste or odour in your mouth?		
34.	Has anyone ever told you that you have bad breath?		
35.	Do your gums and or teeth hurt during cleanings?		
36.	Have you ever had your teeth cleaned with freezing?		
37.	Do you wear any oral piercings (extra or intraoral)? Have you ever? □Yes □No		
38.	Have you had dental work done in a country other than the U.S. or Canada?		

Date: _____ Patient Signature: _____