

DENTAL HISTORY

Referred by _____

Previous dentist _____

How long since last dental visit _____

Most recent dental exam _____

Most recent dental x-ray _____

Most recent dental treatment _____

How often do you have your teeth cleaned? 3 mo__ 4 mo __ 6 mo __ 1 year or longer__

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

1. unhappy with the appearance of your teeth.....
2. unfavorable dental experiences
3. dental fears
4. problems with effectiveness or bad reactions to dental anesthetic
5. orthodontic treatment (braces)
6. periodontal (gum) treatment
7. bleeding gums.....
8. avoid brushing any part of your mouth
9. part of your mouth is sensitive to temperature
10. sore teeth
11. a burning sensation in your mouth
12. difficulty swallowing.....
13. an unpleasant taste or odor in your mouth
14. dry mouth, throat, and/or eyes
15. jaw problems (temporomandibular joint)
16. difficulty opening your mouth wide
17. stiff neck muscles.....
18. awaken with an awareness of your teeth or jaws
19. tension headaches.....
20. clench or grind your teeth.....
21. jaw clicking or popping
22. lost any teeth
23. do you sweat or tremble a lot during examination
24. do strange people or places make you afraid.....

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

YES NO (Please check Yes or No)

- Has your present denture been relined? When _____
- Is your present denture a problem? Describe _____
- Satisfied with the appearance _____
- Satisfied with the comfort? _____
- Satisfied with chewing ability? _____

When did you receive your first partial or complete denture? _____

How long have you worn your present denture? _____

Patient's Signature _____ Date _____

Doctor's Remarks: _____

_____ Doctor's Signature _____