

DENTAL HISTORY

Referred by _____

Previous dentist _____

How long _____

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

SUPPLEMENTAL DENTURE HISTORY:

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

- | YES | NO | (Please check Yes or No) |
|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Has your present denture been relined? When _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your present denture a problem? Describe _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Satisfied with the appearance? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Satisfied with the comfort? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Satisfied with the 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 _____