

DENTAL HISTORY

Referred by _____

Previous dentist _____

How Long _____

Last dental treatment _____

Last Dental x-ray _____

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) when
6. Periodontal (gum) treatment when.....
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.....
15. Jaw problems (temporomandibular joint).....
16. Difficulty opening your mouth widely.....
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 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 _____