DENTAL HISTORY

Refered by_____ 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.____

WHAT IS YOU 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, throat, and or eyes……	☐	☐
15.Jaw problems (temporomandibular joint)……	☐	☐
16. Difficulty opening your mouth widely……	☐	☐
17. Stiff neck muscles……	☐	☐
18. Awakening 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 placese 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 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_____