

Patient Name: _____ Date: _____

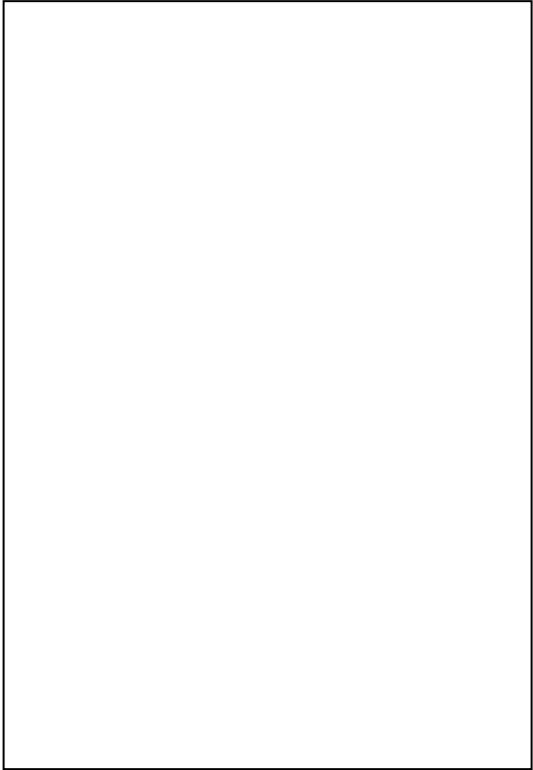
Last dental exam date: _____ Last dental x-ray date: _____ Last dental cleaning date: _____ Last dental treatment date: _____

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. unfavorable dental experiences..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. dental fears..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. problems with dental anesthetic..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. do you sweat or tremble a lot during examination..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. do strange people or places make you afraid..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. unhappy with the appearance of your smile..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. orthodontic treatment (braces)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. sore teeth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. a burning sensation in your mouth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. dry mouth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. teeth sensitive to sweets..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. teeth sensitive to hot or cold..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. teeth sensitive to biting or chewing..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. lost any teeth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. periodontal (gum) treatment..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. bleeding gums..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. avoid brushing any part of your mouth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. an unpleasant taste or odor in your mouth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. food wedging between back teeth when you chew..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. chew on both sides of your mouth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. jaw problems (temporomandibular joint)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. difficulty opening your mouth widely..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. stiff neck muscles..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. awaken with an awareness of your teeth or jaws..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. headaches..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. clench or grind your teeth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. jaw clicking or popping..... | <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)
- Has your present denture been relined? When? _____
- Is your present denture a problem? Describe: _____
- Satisfied with the appearance? _____
- 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 Signature: _____ Date: _____