DENTAL HISTORY

Referred by_____

Previous dentist_____ How long_____

Last dental exam_____ Last dental x-ray_____

Last 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) 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 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_____