

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:

For Office Use Only

- | | 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 hot or cold | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. teeth sensitive to sweets | <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) |
|--------------------------|--------------------------|--|
| <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 comfort? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 _____

DENTAL HISTORY