DENTAL HISTORY

NAME_____

Previous Dentist_____
For how long?_____

Please circle your answer:
When was your last dental exam? 1-3 months 4-6 months 6-12 months 1-2 years 2+ years

How often do you have your teeth cleaned? *Every:* 3 months 4 months 6 months 1 year or longer

WHAT IS YOUR IMMEDIATE DENTAL CONCERN?
_____
_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

Yes no Are you self-conscious of your teeth and/or smile?
Yes no Do you like the color of your teeth?
Yes no Do you have spaces between your teeth that bother you?
Yes no Do you have chips or uneven edges on your teeth?
Yes no Do you feel that your teeth are too long or too short?
Do you have dark fillings that show when you smile?
Yes no Do you avoid brushing any part of your mouth?
Is any part of your mouth sensitive to temperature?
Yes no Do you have sore teeth?
Yes no Any burning sensation in your mouth?
Bleeding gums?
Yes no Difficulty swallowing?
Yes no Any unpleasant taste or odor in your mouth?
Yes no Dry mouth, throat and/or eyes?
Yes no Jaw problems (temporomandibular joint)
Yes no
Yes no
Yes no

Yes no Do you have difficulty opening your mouth widely?
Yes no Stiff neck muscles
Yes no Tension headaches
Yes no Do you clench or grind your teeth?
Yes no Do you experience jaw clicking or popping?
Yes no Have you lost any teeth?
Yes no Have you had an unfavorable dental experience?
Do you have dental fears?
Yes no Problems with effectiveness or bad reactions to
Yes no dental anesthetic
Have you had periodontal (gum) treatment
Yes no If yes, when? _____
Have you had orthodontic treatment (braces) If yes,
Yes no when?_____
Do you sweat or tremble a lot during an exam?
Yes no Do strange/unknown people or places make you
Yes no afraid?

Is there anything else that you would like us to be aware of regarding your oral [illegible]
_____
_____
What sports do you participate in?_____
Where do you get your water supply from?_____City_____Own well_____Bottled

SUPPLEMENTAL DENTURE HISTORY

If you are wearing a partial or complete artificial denture, please complete the following:
Has your present denture been relined? When_____
Is your present denture a problem? Explain_____
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 SIGNATURE _____DATE_____