DENTAL HISTORY

Referred by : _____
Previous Dentist _____ How Long: _____
Most recent dental exam: _____ Most recent x-ray _____
Most recent dental treatment: _____
How often do you have your teeth cleaned ? 3 mo. _____ 4 mo. _____ 6 mo. _____ 1 yr. _____

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, throat, and or eyes.....	☐	☐
15. Jaw problems	☐	☐
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 dental exams	☐	☐
24. Are you overly afraid of unknown people or places	☐	☐

If you Currently have Dentures : partial ☐ or complete ☐
When did you receive your first partial or complete denture: _____
How long have you worn your current denture? _____
Has your current denture been relined? _____ When _____
Is your present denture a problem? _____ Describe: _____
Are you satisfied with the appearance ☐ Yes ☐ No
Are you satisfied with the comfort ☐ Yes ☐ No
Are you satisfied with your ability to chew ☐ Yes ☐ No

Patient's Signature _____Date: _____

Doctor's Remarks: _____

Dr.s' Signature: _____