

# DENTAL HISTORY

Referred by \_\_\_\_\_

Previous dentist \_\_\_\_\_

How long \_\_\_\_\_

Most recent dental exam \_\_\_\_\_

Most Recent dental x-ray \_\_\_\_\_

Most recent 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 .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. unfavorable dental experiences .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. dental fears .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. problems with effectiveness or bad reactions to dental anesthetic ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. orthodontic treatment (braces) when .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. periodontal (gum) treatment when .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. bleeding gums .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. avoid brushing any part of your mouth .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. part of your mouth is sensitive to temperature .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. sore teeth .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. a burning sensation in your mouth .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. difficulty swallowing .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. an unpleasant taste or odor in your mouth .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. dry mouth, throat, and or eyes .....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. jaw problems (temporomandibular joint) .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. difficulty opening your mouth widely .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. stiff neck muscles .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. awaken with an awareness of your teeth or jaws .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. tension headaches .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. clench or grind your teeth .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. jaw clicking or popping .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. lost any teeth .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. do you sweat or tremble a lot during examination .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. do strange people or places make you afraid .....                      | <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 the comfort? _____                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 \_\_\_\_\_