

Dental History

Patient Name _____ Date _____

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 _____ 6mo _____ 1year or longer? _____

Please answer YES or NO to the following:

- | | | |
|--|-----|----|
| 1. Unhappy with the appearance of your teeth | YES | NO |
| 2. Unfavorable dental experiences | YES | NO |
| 3. Dental fears | YES | NO |
| 4. Problems with effectiveness or bad reactions to dental anesthetic ... | YES | NO |
| 5. Orthodontic treatment (braces) when | YES | NO |
| 6. Periodontal (gum) treatment | YES | NO |
| 7. Bleeding gums | YES | NO |
| 8. Avoid brushing any part of your mouth | YES | NO |
| 9. Part of your mouth is sensitive to temperature..... | YES | NO |
| 10. Sore teeth | YES | NO |
| 11. A burning sensation in your mouth..... | YES | NO |
| 12. Difficulty swallowing..... | YES | NO |
| 13. An unpleasant taste or odor in your mouth..... | YES | NO |
| 14. Dry mouth, throat, or eyes..... | YES | NO |
| 15. Jaw problems (temporomandibular joint)..... | YES | NO |
| 16. Difficulty opening your mouth widely..... | YES | NO |
| 17. Stiff neck muscles..... | YES | NO |
| 18. Awaken with an awareness of your teeth or jaws..... | YES | NO |
| 19. Tension headaches..... | YES | NO |
| 20. Clench or grind your teeth..... | YES | NO |
| 21. Jaw clicking or popping..... | YES | NO |
| 22. Lost any teeth..... | YES | NO |
| 23. Do you sweat or tremble a lot during examination..... | YES | NO |
| 24. Do strange people or places make you afraid..... | YES | NO |

Supplemental Denture History:

If you are wearing a partial or complete artificial denture, please complete the following:

- YES NO Has your present denture been relined? When _____
- YES NO Is your present denture a problem? Describe _____
- YES NO Satisfied with the appearance? _____
- YES NO Satisfied with the comfort? _____
- YES NO 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 _____ Date _____
