DENTAL HISTORY

Referred by_____

Previous dentist_____How long?_____

Date of last dental exam_____Last dental x-ray_____

Last dental treatment_____

How often do you have your teeth cleaned? 3mths 6mths 9mths or longer

WHAT IS YOUR IMMEDIATE DENTAL CONCERN?_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

1. are you unhappy with the appearance of your teeth_____Y / N
2. have you had any unfavourable dental experiences_____Y / N
3. do you have any dental fears_____Y / N
4. problems with effectiveness or bad reactions to dental anaesthetic_____Y / N
5. orthodontic treatment (braces) when_____Y / N
6. periodontal (gum) treatment when_____Y / N
7. bleeding gums_____Y / N
8. avoid brushing any part of your mouth_____Y / N
9. part of your mouth is sensitive to temperature_____Y / N
10. sore teeth_____Y / N
11. a burning sensation in your mouth_____Y / N
12. difficulty swallowing_____Y / N
13. problems with gagging_____Y / N
14. dry mouth_____Y / N
15. an unpleasant taste or odour in your mouth_____Y / N
16. jaw / temporomandibular (TMJ) problems_____Y / N
17. difficulty opening your mouth widely_____Y / N
18. stiff neck muscles_____Y / N
19. awaken with an awareness of your teeth or jaws_____Y / N
20. tension headaches_____Y / N
21. clench or grind your teeth_____Y / N
22. jaw clicking or popping_____Y / N
23. lost any teeth_____Y / N
24. do you sweat or tremble a lot during examination_____Y / N
25. do strange people or places make you afraid_____Y / N

SUPPLEMENTAL DENTURE HISTORY

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

Y / N Has your present denture been relined? When_____
Y / N Is you present denture a problem? Describe_____
Y / N Satisfied with the appearance?_____
Y / N Satisfied with the comfort?_____
Y / N Satisfied with the chewing ability?_____
When did you receive your first complete or partial denture?_____
How long have you worn your present denture?_____

Patient's Signature_____Date_____

Doctor's Remarks_____

Doctor's Signature

OVER