Dental History

Full Name

Referred by | **Today's 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? ○ **3mo** ○ **4mo** ○ **6mo** ○ **1 year or longer**

What is your immediate dental concern?

Please answer yes or no to the following:

Are you unhappy with the appearance of your teeth?	○ **Yes**	○ **No**
Do your gums bleed when you brush?	○ **Yes**	○ **No**
Have you ever had orthodontic (braces) treatment?	○ **Yes**	○ **No**
Are your teeth sensitive to cold, hot, sweets or pressure?	○ **Yes**	○ **No**
Do you have earaches or neck pains?	○ **Yes**	○ **No**
Have you had any periodontal (gum) treatments?	○ **Yes**	○ **No**
Do you wear removable dental appliances?	○ **Yes**	○ **No**
Have you had an unfavorable dental experience?	○ **Yes**	○ **No**
Do you have any dental fears?	○ **Yes**	○ **No**
Do you have trouble getting numb?	○ **Yes**	○ **No**
Do you have an unpleasant taste or odor in your mouth?	○ **Yes**	○ **No**
Do you have dry mouth, throat or eyes?	○ **Yes**	○ **No**
Do you have jaw problems (temporomandibular joint)?	○ **Yes**	○ **No**
Do you have difficulty opening your mouth widely?	○ **Yes**	○ **No**
Do you have tiff neck muscles?	○ **Yes**	○ **No**
Do you awaken with an awareness of your teeth or jaws?	○ **Yes**	○ **No**

Do you have tension headaches? ○ **Yes** ○ **No**

Do you clench or grind your teeth? ○ **Yes** ○ **No**

Does your jaw click or pop? ○ **Yes** ○ **No**

Have you lost any teeth? ○ **Yes** ○ **No**

Supplemental Denture History:
If you are wearing a partial or complete artificial denture, please complete the following;

Has your present denture been relined? ○ **Yes** ○ **No** **When**

Is your present denture a problem? ○ **Yes** ○ **No** **Describe**

Satisfied with the appearance? ○ **Yes** ○ **No** **Describe**

Satisfied with the comfort? ○ **Yes** ○ **No** **Describe**

Satisfied with the chewing ability? ○ **Yes** ○ **No** **Describe**

When did you receive your first partial or complete denture? **When**

How long have you worn your present denture? **Describe**

Patient's Signature _____ **Date** _____

Doctor's Signature _____ **Date** _____