DENTAL HISTORY

Referred by _____

Previous dentist _____

Last dental exam _____Last dental x-ray_____

Last 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 CHECK THE APPROPRIATE BOX:	Yes	No
1- unhappy with the appearance of your teeth		
2-unfavourable dental experiences		
3- dental fears		
4. problems with effectiveness or bad reactions to dental anaesthetic		
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. any lumps or swelling in your mouth		
12. a burning sensation in your mouth		
13. difficulty swallowing		
14. an unpleasant taste or odour in your mouth		
15. dry mouth		
16. jaw problems (temporomandibular joint)		
17. difficultly opening your mouth widely		
18. stiff neck muscles		
19. awaken with an awareness of your teeth or jaws		
20. tension headaches		
21. clench or grind your teeth		
22. jaw clicking or popping		
23. lost any teeth		

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 _____
Is your present denture a problem?.....			Describe _____
Satisfied with the appearance?.....			
Satisfied with the comfort?.....			
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_____

Doctor's Remarks: _____

Doctor's Signature_____ Date _____