Dental History

Previous dentist _____ Specialty _____ Treatment Period _____

Address _____ Phone number _____
Number Street City State Zip

Last dental visit _____ Last full-mouth x-ray _____ Last complete dental exam _____

Last cleaning _____ How often do you get your teeth cleaned? _____

Please encircle **YES** or **NO**. If **YES**, please fill in details.

YES **NO** Are you presently in any dental pain? _____

YES **NO** Have you ever had orthodontal treatment? When? _____

YES **NO** Do you have any growths or swellings in your mouth? How long? _____

YES **NO** Do you have any difficulty in swallowing? _____

YES **NO** Do your gums bleed when brushing your mouth? _____

YES **NO** Have you ever been told you have pyorrhea? When? _____

YES **NO** Is any part of our mouth sensitive to temperature, pressure, food, or drink? What?

_____

YES **NO** Do you have a burning sensation in your mouth? _____

YES **NO** Have you ever had a bad reaction to a dental anesthetic? When? _____

YES **NO** Does food catch between your teeth? _____

YES **NO** Do you have any pain or soreness around your eyes, ears, or other parts of your face? When?

_____

YES **NO** Are you aware of stiff neck muscles? How often? _____

YES **NO** Do you ever awaken with an awareness of your teeth or jaws? How often? _____

YES **NO** Are you aware of clenching your teeth during your daytime hours? How often? _____

YES **NO** Have you ever been told you grind your teeth during sleep? How often? _____

YES **NO** Are you aware of your jaw clicking or popping while eating or yawning? How often? _____

YES **NO** Do you have difficulty opening your mouth widely? _____

YES **NO** Do you have "tension" headaches? How often? _____

YES **NO** Do you have an unpleasant taste or odor in your mouth? _____

YES **NO** Are you dissatisfied with your teeth and their appearance? _____

YES **NO** Do you feel you will eventually wear full artificial dentures? _____

YES **NO** Have you ever suffered trauma to your head or neck, such as in a car accident? When?

_____

YES **NO** Have you ever received radiation therapy to your head or neck? When? Why?

_____

YES **NO** Have you ever had periodontal treatment or surgery? When? By whom?

_____

Supplemental Denture History

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

For what reason were your teeth lost? _____

_____

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

Approximate date of extractions _____

Was your first complete or partial denture placed the same day the teeth were extracted? _____

How many complete or partial dentures have you had? Upper _____ Lower _____

How long have you worn your present denture? _____

Has it been relined? _____

Your last denture was constructed by _____

What is your present denture problem? _____

Are you satisfied with the appearance? _____

Are you satisfied with the comfort? _____

Are you satisfied with the chewing ability? _____

Do you wear your dentures 24 hours a day? _____ If not, why not? _____

Do you bite your tongue or your cheek with your dentures? _____

Do your dentures click during speech? _____

Is your speech influenced by your dentures? _____ How? _____

What do you expect of your new denture? _____

Please be sure to obtain a copy of Office Policy regarding financial arrangements.