PATIENT DENTAL HISTORY

DATE _____ PATIENT _____

NAME OF YOUR FORMER DENTIST	DATE OF LAST DENTAL EXAM	MAY WE SEND FOR YOUR RECORDS?

ADDRESS OF FORMER DENTIST	CITY	STATE	ZIP

WHY DID YOU DECIDE TO CHANGE DENTISTS? _____

IS THERE ANYTHING WE CAN DO TO MAKE YOUR DENTAL TREATMENT HERE MORE COMFORTABLE? _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

HOW OFTEN DO YOU USUALLY HAVE YOUR TEETH PROFESSIONALLY CLEANED? _____

HOW OFTEN DO YOU BRUSH? _____ HOW OFTEN DO YOU FLOSS? _____

DO YOU USE ANY OTHER ORAL HYGIENE AIDS? _____

DO YOU USE A "TARTAR CONTROL" TOOTHPASTE? _____ FLUORIDE TOOTHPASTE? _____

PLEASE CHECK IF YOU HAVE, OR HAVE EVER HAD THE FOLLOWING:

UNFAVORABLE DENTAL EXPERIENCES	☐	_____
PROBLEMS GETTING NUMB WITH DENTAL ANESTHETIC	☐	_____
UNFAVORABLE REACTION TO DENTAL ANESTHETIC OR NITROUS	☐	_____
PREFER TO USE NITROUS OXIDE DURING DENTAL CARE	☐	_____
BLEEDING OR "ITCHING" GUMS	☐	_____
UNPLEASANT TASTE OR ODOR IN YOUR MOUTH	☐	_____
PERIODONTAL (GUM) TREATMENT. HOW LONG AGO?	☐	_____
ORTHODONTIC (BRACES) TREATMENT. HOW LONG AGO?	☐	_____
ORAL SURGERY (TOOTH EXTRACTION OR BIOPSY). HOW LONG AGO?	☐	_____
LUMP OR SWELLING IN YOUR HEAD OR NECK REGION	☐	_____
SENSITIVITY TO HOT OR COLD AIR, LIQUIDS OR FOODS	☐	_____
PAIN OR SORENESS ON CHEWING OR BITING	☐	_____
DRY MOUTH. DO YOU USE LOZENGES OR COUGH DROPS TO CORRECT?	☐	_____
BURNING SENSATION IN YOUR MOUTH	☐	_____
DIFFICULTY SWALLOWING	☐	_____
NEED TO USE ANTACIDS (TUMS/ROLAIDS/MYLANTA)?	☐	_____
JAW PROBLEMS (TEMPOROMANDIBULAR JOINT)	☐	_____
DIFFICULTY OR PAIN OPENING WIDE	☐	_____
JAW "CLICKING" OR "POPPING"	☐	_____
AWAKEN WITH AWARENESS OF TEETH OR JAWS OR WITH HEADACHES	☐	_____
DO YOU HAVE AN OCCLUSAL OR NITE GUARD? IF SO, DO YOU WEAR IT?	☐	_____
CLENCH OR GRIND YOUR TEETH	☐	_____
TRAUMA OR INJURY TO YOUR HEAD OR NECK	☐	_____
UNHAPPY WITH THE APPEARANCE OF YOUR TEETH?	☐	_____

SUPPLEMENTAL DENTURE HISTORY:

IF YOU ARE WEARING A PARTIAL OR COMPLETE DENTURE, PLEASE COMPLETE THE FOLLOWING:

YES	NO	(PLEASE CHECK YES OR NO)	
☐	☐	HAS YOUR PRESENT DENTURE BEEN RELINED?	WHEN? _____
☐	☐	IS YOUR PRESENT DENTURE A PROBLEM? IF SO, PLEASE 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?	_____

IN ADDITION TO THE INFORMATION YOU HAVE GIVEN US, IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOU, YOUR MOUTH, OR YOUR HEALTH THAT WILL HELP US TO PROVIDE THE TYPE OF DENTAL CARE YOU DESIRE: _____