MAIN STREET DENTAL

Dental History

Previous dentist: _____ How long: _____

Most recent dental exam: _____ Most recent dental x-rays: _____

Most recent dental treatment: _____ How often do you have your teeth cleaned? ❑ 3mo. ❑ 4mo. ❑ 6mo. ❑ 1 year

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

Have you ever had any of the following?	**YES**	**NO**
1. unhappy with appearance of your teeth	❑	❑
2. unfavorable dental experiences	❑	❑
3. dental fears	❑	❑
4. problems with effectiveness or bad reactions to dental anesthetic	❑	❑
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. a burning sensation in your mouth	❑	❑
12. difficulty swallowing	❑	❑
13. an unpleasant taste or odor in your mouth	❑	❑
14. dry mouth, throat, and or eyes	❑	❑
15. jaw problems (temporomandibular joint)	❑	❑
16. difficulty opening your mouth widely	❑	❑
17. stiff neck muscles	❑	❑
18. awaken with an awareness of your teeth or jaws	❑	❑
19. tension headaches	❑	❑
20. clench or grind your teeth	❑	❑
21. jaw clicking or popping	❑	❑
22. lost any teeth	❑	❑
23. do you sweat or tremble a lot during examination	❑	❑
24. do strange people or places make you afraid	❑	❑

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 appearance?	❑	❑
Satisfied with comfort?	❑	❑
Satisfied with chewing ability?	❑	❑

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

How long have you worn your present denture? _____

PATIENT SIGNATURE: _____ **DATE:** _____

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