

SUPPLEMENTAL MEDICAL & DENTAL HISTORY

Patient name: _____

Name of physician: _____

Physician's address: _____ Phone () _____

Date of last complete medical exam? _____

Previous dentist name: _____ Phone () _____

Address: _____

Last dental visit? _____ Last full mouth xray? _____ Last complete dental exam? _____

What is your immediate dental concern? (Reason for visit) _____

PLEASE CHECK

Have you had orthodontic treatment (braces)? YES NO

If so, when? _____

Where? _____

Do you have growths or swellings in your mouth? YES NO

If yes. How long have they existed? _____

Do you have difficulty swallowing? YES NO

Do your gums bleed when you brush your teeth? YES NO

Do you avoid brushing any part of your mouth? YES NO

Why? _____

Have you ever been told you have pyorrhea or periodontal disease? YES NO

Is any part of your mouth sensitive to hot or cold, pressure, food or liquids? YES NO

If yes, what areas are involved? _____

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

Does food get caught between your teeth? YES NO

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

If yes, when? _____

Are you aware of stiff neck muscles? YES NO

If yes, how often? _____

Do you ever awake with an awareness of your teeth and jaws? YES NO

If yes, how often? _____

Are you aware of clenching your teeth during the daytime? YES NO

If yes, how often? _____

Have you ever been told you grind your teeth while asleep? YES NO

Are you aware of your jaw clicking & popping while eating or yawning? YES NO

If yes, how often? _____

Do you have difficulty opening your mouth wide? YES NO

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

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

Do you feel you will eventually wear artificial dentures? YES NO

Do any of your family members including your parents wear dentures? YES NO

Do you want to learn how to keep your mouth as healthy as possible in order to retain your teeth? YES NO

Are you deeply concerned about the finances required to return your mouth to excellent dental health? YES NO

Do you get frustrated because you always have something to be treated or repaired when you visit a dentist? YES NO