

# Walla Walla Dental Care

Name: \_\_\_\_\_ **DENTAL HISTORY**

Referred by \_\_\_\_\_

Previous Dentist \_\_\_\_\_ How long \_\_\_\_\_

Most recent dental exam \_\_\_\_\_ Most recent dental xray \_\_\_\_\_

Most recent dental treatment \_\_\_\_\_

How often do you have your teeth cleaned? 3mo \_\_\_ 4mo \_\_\_ 6mo \_\_\_ 1 year or longer \_\_\_

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? \_\_\_\_\_

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

- Unhappy with the appearance of your teeth.....  YES  NO
- Unfavorable dental experiences.....  YES  NO
- Dental fears.....  YES  NO
- Problems with effectiveness or bad reactions to dental anesthetic.....  YES  NO
- Orthodontic treatment (braces) When? \_\_\_\_\_  YES  NO
- Periodontal (gum) treatment When \_\_\_\_\_  YES  NO
- Bleeding gums.....  YES  NO
- Avoid brushing any part of your mouth.....  YES  NO
- Part of your mouth is sensitive to temperature.....  YES  NO
- Sore teeth.....  YES  NO
- A burning sensation in your mouth.....  YES  NO
- Difficulty swallowing.....  YES  NO
- An unpleasant taste or odor in your mouth.....  YES  NO
- Dry mouth, throat, and or eyes.....  YES  NO
- Jaw problems (temporomandibular joint).....  YES  NO
- Difficulty opening you mouth widely.....  YES  NO
- Stiff neck muscles.....  YES  NO
- Awaken with an awareness of your teeth or jaws.....  YES  NO
- Tension headaches.....  YES  NO
- Clench or grind your teeth.....  YES  NO
- Jaw clicking or popping.....  YES  NO
- Lost any teeth.....  YES  NO
- Do you sweat or tremble a lot during an examination.....  YES  NO
- Do strange/unknown people or places make you afraid.....  YES  NO

## SUPPLEMENTAL DENTURE HISTORY

If you are wearing a partial or complete artificial 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? Explain \_\_\_\_\_

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? \_\_\_\_\_

PATIENTS SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DOCTORS SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_