PHILLIPS SCHMITT
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DENTAL HISTORY

Referred by:_____ Previous Dentist:_____

How Long?_____ Last Dental Exam:_____ Last Dental X-ray:_____

Last Dental Treatment:_____

How often do you have your teeth cleaned? ❒ 3 mos. ❒ 4 mos. ❒ 6 mos. ❒1 year or longer?

WHAT IS YOUR IMMEDIATE DENTAL CONERN? _____

1. Unhappy with the appearance of your teeth? ..... YES or NO
2. Unfavorable dental experience? ..... YES or NO
3. Dental fears? ..... YES or NO
4. Problems with effectiveness or bad reactions to dental anesthetic? ..... YES or NO
5. Orthodontic treatment (braces)? ..... YES or NO
6. Periodontal (gum) disease? ..... YES or NO
7. Bleeding gums? ..... YES or NO
8. Avoid brushing any part of your mouth? ..... YES or NO
9. Part of your mouth is sensitive to temperature? ..... YES or NO
10. Sore teeth? ..... YES or NO
11. A burning sensation in your mouth? ..... YES or NO
12. Difficulty swallowing? ..... YES or NO
13. An unpleasant taste or odor in your mouth? ..... YES or NO
14. Dry mouth? ..... YES or NO
15. Jaw problems (temporomandibular joint)? ..... YES or NO
16. Difficulty opening your mouth widely? ..... YES or NO
17. Stiff neck muscles? ..... YES or NO
18. Awaken with an awareness of your teeth or jaws? ..... YES or NO
19. Tension headaches? ..... YES or NO
20. Clench or grind your teeth? ..... YES or NO
21. Jaw clicking or popping? ..... YES or NO
22. Lost any teeth? ..... YES or NO
23. Do you sweat or tremble a lot during examination? ..... YES or NO
24. Do strange people or places make you afraid? ..... YES or NO

SUPPLEMENTAL DENTURE HISTORY

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

Has your present denture been realigned? When? _____

Is your present denture a problem? 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? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____