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……	□	□
Unfavorable dental experiences……	□	□
Dental fears…….……	□	□
Problems with effectiveness or bad reactions to dental anesthetic…….	□	□
Orthodontic treatment (braces) When?_____.....	□	□
Periodontal (gum) treatment When_____.....	□	□
Bleeding gums…….....	□	□
Avoid brushing any part of your mouth……...	□	□
Part of your mouth is sensitive to temperature……	□	□
Sore teeth…….....	□	□
A burning sensation in your mouth…….	□	□
Difficulty swallowing……	□	□
An unpleasant taste or odor in your mouth……..	□	□
Dry mouth, throat, and or eyes……....	□	□
Jaw problems (temporomandibular joint)…….. .	□	□
Difficulty opening you mouth widely……..	□	□
Stiff neck muscles…….....	□	□
Awaken with an awareness of your teeth or jaws……	□	□
Tension headaches……...	□	□
Clench or grind your teeth……	□	□
Jaw clicking or popping……	□	□
Lost any teeth……	□	□
Do you sweat or tremble a lot during an examination……	□	□
Do strange/unknown 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 (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_____