WESTHILL DENTAL EXCELLENCE

Dental History

www.westhilldentalappleton.com
Appleton: (920) 733-2445
Greenville: (920) 954-1110

Welcome! So that we may provide you with the best possible care,
please take a moment to fill out both sides of this form as completely as you can.

Patient's Name _____ Date of Birth _____ ☐ Male ☐ Female
Last First Initial

Please check Yes or No and/or complete in detail.

1. Reason you made this appointment _____
2. When did you last visit the dentist _____
3. How often did you visit the dentist before then? _____
4. Are you presently in any dental pain? YES NO
   If yes, please describe _____
5. Have you ever had an unpleasant experience at the dentist? YES NO
   If yes, please describe _____
6. Have you ever had:
   orthodontic treatment? YES NO
   If yes, give year _____
   periodontal treatment? YES NO
   If yes, give year _____
   oral surgery? YES NO
   If yes, give year _____
   your bite adjusted? YES NO
   If yes, give year _____
   root canal treatment? YES NO
   If yes, give year _____
   cosmetic dentistry? YES NO
   If yes, give year _____
   dental implants? YES NO
   If yes, give year _____
7. Have you ever lost any teeth? YES NO
   If yes, from what cause and when? _____
8. Have you ever had any injury to the head, jaws, or mouth? YES NO
   If yes, from what cause and when? _____
9. Are you satisfied with your teeth and their appearance? YES NO
   What would you like to change, ideally? _____
10. Does dental treatment make you nervous? YES NO
    If yes, ☐ Moderately or ☐ Extremely
11. Do you want to learn how to control dental disease and retain your natural teeth? YES NO
12. Are you deeply concerned about the finances required to return your mouth to excellent dental health? YES NO
13. Have you ever neglected, canceled, or not shown up for dental appointments in the past? YES NO
    If yes, explain reasons _____

Oral Health

1. How often do you brush your teeth? _____
2. Do you floss your teeth? YES NO
   If yes, how often? _____
3. Do you use a fluoride or other rinse? YES NO
   If yes, how often? _____
4. Do your gums bleed when you brush? YES NO
5. Do you use any other dental aids? (toothpick, electric toothbrush, etc.) YES NO
   If yes, what? _____
6. Does food tend to become caught between your teeth? YES NO
   If yes, where? _____
7. Do you hold foreign objects in your teeth (pencils, pipes, pins, fingernails)? YES NO
8. Have you ever had professional instructions in oral hygiene? YES NO

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Have you ever experienced any of the following? (check boxes that apply)

- ☐ Sore gums
- ☐ Unpleasant taste, odor/bad breath
- ☐ Burning tongue, lips
- ☐ Frequent blisters, cold sores
- ☐ Dry mouth
- ☐ Swelling/lumps in mouth
- ☐ Clicking/popping jaw joint
- ☐ Difficulty opening/closing jaw
- ☐ Clenching/grinding teeth
- ☐ Soreness in facial muscles
- ☐ Headaches, neck aches and/or shoulder pain
- ☐ Change in bite
- ☐ Loose teeth
- ☐ Teeth sensitive to hot
- ☐ Teeth sensitive to cold
- ☐ Teeth sensitive to sweets
- ☐ Biting lips or cheeks
- ☐ Shifting in teeth
- ☐ Snoring

Please check one box below per section

1. ☐ Think the appearance of my mouth is excellent.
   ☐ Think the appearance of my mouth is adequate.
   ☐ Wish I could change the appearance of my mouth.
2. ☐ Want to save my teeth at all costs.
   ☐ Prefer to keep my teeth if cost & time are reasonable.
   ☐ Expect to someday loose my teeth and have dentures.
3. ☐ Have set goals to achieve optimum oral health with a previous dentist.
   ☐ Want to set goals concerning my dental health
   ☐ Usually only go to the dentist for problems or emergencies
4. ☐ Desire EXCELLENT oral health.
   ☐ Desire AVERAGE OR GOOD oral health.
   ☐ Desire crisis care only.
5. ☐ Have always done the best what was recommended for my dental health.
   ☐ Have not done what dentists recommended for me.
   ☐ Rarely go, and don't care much about having any dental work completed.

If you are wearing a PARTIAL or COMPLETE denture please complete boxed in area below.

1. For what reason did you loose your teeth? _____
1. When did you receive your first denture? _____
2. How many complete or partial dentures have you had? Upper _____ Lower _____
3. How long have you worn your present denture? Upper _____ Lower _____
4. Has it been relined? ◯ YES ◯ NO
   If yes, how long ago _____
5. Who made your last denture? _____
6. Do you have a present denture problem? ◯ YES ◯ NO
   If yes, please describe _____
7. Are you satisfied with their appearance? ◯ YES ◯ NO
   If no, why? _____
8. Are you satisfied with the comfort? ◯ YES ◯ NO
   If no, why? _____
9. Are you satisfied with the chewing ability? ◯ YES ◯ NO
   If no, why? _____
10. Do you wear your dentures 24 hours a day? ◯ YES ◯ NO
11. Do you bite your tongue or cheeks with your dentures? ◯ YES ◯ NO
12. Do your dentures click during speech? ◯ YES ◯ NO
13. Is your speech influenced by your dentures? ◯ YES ◯ NO
    If yes, describe _____
14. What do you expect from your new dentures (partial or complete)? _____
15. Are you interested in hearing about dental implants? ◯ YES ◯ NO

Please add any comments that you feel will assist this dental team in our concern for your treatment.

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my medical dental health, I will inform the dentist at my next appointment.

Patient's or Guardian's Signature _____ Date _____