

INITIAL CLINICAL EXAMINATION

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| PATIENT NAME _____ | WISHES TO BE CALLED _____ |
| PATIENT ACCOUNT NO. _____ | DATE _____ |

INITIAL CONCERN _____

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| DATE OF LAST DENTAL VISIT _____ | DATE OF LAST DENTAL CLEANING _____ | DATE OF LAST FULL MOUTH SERIES OF X-RAYS _____ |
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| <p>1. ARE YOU HAVING PAIN AT THIS TIME? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. HAVE YOU EVER HAD:</p> <p style="padding-left: 20px;">a. ORTHODONTIC TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">b. ORAL SURGERY? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">c. PERIODONTAL TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">d. YOUR TEETH GROUND OR THE BITE ADJUSTED? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">e. WORN A BITE PLATE OR OTHER APPLIANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. DO YOU SUFFER FROM PAIN AND/OR SWELLING OF YOUR GUMS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. DO YOUR GUMS OFTEN BLEED WHEN YOU BRUSH YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. PROBLEMS OF THE JAW. HAVE YOU EXPERIENCED:</p> <p style="padding-left: 20px;">a. CLICKING OF THE JAW? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">b. PAIN (JOINT, EAR, SIDE OF FACE)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">c. DIFFICULTY IN OPENING OR CLOSING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">d. DIFFICULTY IN CHEWING? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>8. HABITS. DO YOU:</p> <p style="padding-left: 20px;">a. CLENCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">b. BITE YOUR LIPS OR CHEEKS REGULARLY? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">c. HOLD FOREIGN OBJECTS WITH YOUR TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="padding-left: 20px;">d. MOUTH BREATHE WHILE AWAKE OR ASLEEP? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <p>9. DO YOU FEEL VERY NERVOUS ABOUT HAVING DENTAL TREATMENT? . <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>10. HAVE YOU EVER HAD AN UPSETTING EXPERIENCE IN A DENTAL OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>11. IS IT IMPORTANT TO KEEP YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>12. DO YOU LIKE THE APPEARANCE OF YOUR TEETH, YOUR SMILE? .. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>13. DO YOU HAVE ANY OLD FILLINGS OR DENTAL WORK YOU DONT LIKE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>14. WHAT WOULD YOU LIKE TO CHANGE MOST IN THE APPEARANCE OF YOUR TEETH? EXPLANATION: _____ _____</p> <p>15. IS THERE ANYTHING ELSE ABOUT HAVING DENTAL TREATMENT THAT BOTHERS YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO EXPLANATION: _____ _____</p> <p>16. WHAT TYPE OF TOOTHBRUSH DO YOU USE? SOFT ___ MEDIUM ___ HARD ___</p> <p>17. DO YOU USE DENTAL FLOSS? <input type="checkbox"/> YES <input type="checkbox"/> NO HOW OFTEN? _____</p> <p>18. WHEN DO YOU BRUSH? <input type="checkbox"/> MORNINGS <input type="checkbox"/> EVENINGS</p> <p>19. DO YOU USE ANY OTHER ORAL HYGIENE DEVICES? <input type="checkbox"/> INTERPLAK <input type="checkbox"/> STIMULATORS <input type="checkbox"/> PROXYBRUSHES <input type="checkbox"/> FLUORIDE</p> |
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| MEDICAL ALERT _____ | PREMEDICATION _____ |
| _____ | B.P. _____ PULSE _____ |
| CURRENT MEDICATIONS _____ | |

