INITIAL CLINICAL EXAM

Patient Name _____ Date _____

Initial Concern _____

Date of Last Dental Visit	Date of Last Dental Cleaning	Date of Last BWX, FMX or Panorex

YES	NO	
☐	☐	Are you in pain at this time? _____
☐	☐	Do you have any pain in your teeth from hot, cold, or sweets? _____
☐	☐	Do you have any pain in your mouth or teeth while biting or chewing? _____
☐	☐	Do you ever experience a burning sensation of the tongue? _____
☐	☐	Have you had orthodontic treatment? Completed by _____
		When _____ How long _____ Retainers _____
☐	☐	Have you had local anesthetic? _____
☐	☐	Have you had your wisdom teeth removed? _____
☐	☐	Have you had any other teeth removed? How long ago? _____
☐	☐	Were options discussed to restore spaces? _____
☐	☐	Have you been told you have gum disease? Treated by _____
☐	☐	Have you noticed any loosening of your teeth? _____
☐	☐	Do your gums feel irritated, swollen or tender? _____
☐	☐	Do your gums bleed when chewing, brushing or flossing? _____
☐	☐	Did you know damage to the bone under the gums can take place before the patient can feel anything? _____
☐	☐	Have you ever had professional instructions on home care? _____
☐	☐	Brushing _____ Flossing _____
☐	☐	Do you avoid any part of your mouth? _____
☐	☐	Do you smoke? How much _____ How long _____
☐	☐	Does food or floss catch between your teeth? _____
☐	☐	Does patient wear prosthetics? _____
☐	☐	Do you breath through your mouth while awake or asleep? _____
☐	☐	Do you chew on both sides of your mouth? _____
☐	☐	Do you have a tired feeling in your face while chewing or at end of day? _____
☐	☐	Do you hold foreign objects between your teeth (Pens, fingernails, toothpicks) _____
☐	☐	Do you bite your lips or cheeks regularly? _____
☐	☐	Have you been made aware of clenching or grinding? _____
		Grinding: am/pm Clenching: am/pm Muscle Soreness: am/pm
☐	☐	Do you experience difficulty opening or closing? _____
☐	☐	Do you experience pain (joint, ear, side of face)? _____
☐	☐	Do you experience joint noise (popping, clicking)? _____
☐	☐	Have you ever experienced locking of the jaw? _____
☐	☐	Headaches per week: _____
☐	☐	Do you have ringing in your ears? _____
☐	☐	Have you been treated for TMJ? _____
☐	☐	Bite Splint _____ Other Appliance _____ Equilibrated _____
☐	☐	How often have you had a prophy? _____ Amount of time? _____
☐	☐	Do you go to the dentist regularly and how often were x-rays taken? _____
☐	☐	Is it important for you to keep your teeth? _____
☐	☐	Are you unhappy with the appearance of your teeth? _____
☐	☐	Are study models needed? _____
☐	☐	Do you drink pop, juice, milk, sports drinks? _____
		How often? _____
☐	☐	Do you snack between meals? _____
☐	☐	Is there anything that you would like to tell me? _____