DENTAL HISTORY

Patient Name: _____ DOB: _____ Today's Date: _____

Previous Dentist: _____ Date of most recent dental exam: _____

Date of most recent x-rays: _____ Date of most recent dental treatment (other than a cleaning): _____

How would you rate the condition of your mouth?: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

I routinely see my dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**Yes**	**No**

PERSONAL HISTORY

1. Are you fearful of dental treatment? What is your level of dental anxiety? _____ (1-least, 10-most) ……	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Have you ever had braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth or lost teeth due to injury or facial trauma?	☐	☐
7. Do you use an electric toothbrush?	☐	☐
8. Do you floss daily?	☐	☐
9. Do you currently use prescription fluoride toothpaste (e.g. Clinpro 5000, Prevident 5000)? ……..	☐	☐

10. Which of these factors matter most to your dental health? Can be multiple answers.
    - ☐ Appearance of your smile
    - ☐ Long lasting dentistry
    - ☐ Your comfort (you're free from cavities, gum disease and infection)
    - ☐ Functionality of your teeth
11. When considering treatment options for your care, which of these are concerns for you? Can be multiple answers.
    - ☐ Fear of dental work
    - ☐ Lack of trust with dentists
    - ☐ Treatment not important right now
    - ☐ Not the right time for me to have treatment done
    - ☐ Cost of dental care
12. When it comes to explaining your dental treatment, which is best for you? Can be multiple answers.
    - ☐ I'm a visual person so I want to see photos, x-rays, drawings, etc.
    - ☐ I want to know why and I want everything explained with every little detail
    - ☐ Just give me enough detail so I understand my treatment
    - ☐ Just tell me what I need to do, spare all the details
    - ☐ I like multiple options that I can pick and choose (e.g. dentures, implants, bridges)
    - ☐ I want what Dr. Wonder thinks is best for my teeth/mouth

GUM AND BONE

13. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
14. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
15. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
16. Is there anyone in your family with a history of periodontal (gum) disease?	☐	☐
17. Have you ever experienced a gum recession?	☐	☐
18. Have you ever had any teeth become loose on their own (without an injury)?	☐	☐
19. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐

TOOTH STRUCTURE

20. Have you ever had any cavities within the past 3 years?	☐	☐
21. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
22. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
23. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
24. Do you have or feel grooves or notches on your teeth near the gum line?	☐	☐
25. Have you ever broken teeth, chipped/cracked teeth or had a toothache or cracked fillings?	☐	☐
26. Do you frequently get food caught between any teeth?	☐	☐

BITE AND JAW JOINT

27. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)..... ⬜ ⬜
28. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?..... ⬜ ⬜
29. Do you avoid or have difficulty chewing gum, carrots, nuts, baguettes, or other hard dry foods?..... ⬜ ⬜
30. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?..... ⬜ ⬜
31. Are your teeth becoming more crooked, crowded, or overlapped?..... ⬜ ⬜
32. Are your teeth developing spaces or becoming more loose?..... ⬜ ⬜
33. Do you have trouble finding your bite or shift your jaw to make your teeth fit together?..... ⬜ ⬜
34. Do you place your tongue between your teeth or close your teeth against your tongue?..... ⬜ ⬜
35. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? …… ⬜ ⬜
36. Do you clench or grind your teeth together in the daytime or make them sore?…… ⬜ ⬜
37. Do you have any problems with sleep (i.e. restless or teeth grinding), or wake up with a headache?..... ⬜ ⬜
38. Do you wear or have you ever worn a bite appliance (i.e. TMJ appliance or a night guard)..... ⬜ ⬜
39. If needed, would you like to discuss orthodontic treatment (braces) with Dr. Wonder?..... ⬜ ⬜

SMILE CHARACTERISTICS

40. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?..... ⬜ ⬜
41. Have you ever whitened (bleached) your teeth?..... ⬜ ⬜
42. Do you feel uncomfortable or self-conscious about the appearance of your teeth or when you smile?..... ⬜ ⬜
43. Have you been disappointed with the appearance of previous dental work?..... ⬜ ⬜
44. Would you like to discuss the whitening procedure with Dr. Wonder?..... ⬜ ⬜

SLEEP & BREATHING

45. Do you have trouble breathing through your nose?..... ⬜ ⬜

Patient/Parent/Guardian Signature: _____ **Date:** _____