Wohlers
FAMILY DENTISTRY

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DENTAL HISTORY

1. Patient Name _____
2. What is the reason for your visit today?_____
   _____
3. Date of last dental visit_____Last dental cleaning_____Last full mouth X-Rays_____
4. What was done at your last dental visit? _____
   _____
5. Previous Dentist's Name _____
   Address/State/Zip_____
   Telephone_____
6. How often do you have dental examinations?_____
7. How often do you brush your teeth?_____How often do you floss? _____
8. Have you ever used or are currently using topical fluoride? ……...❒ Yes ❒ No
9. What other dental aids do you use? (Waterpik, toothpick, etc.)_____
10. **Do you have any dental problems now?** ..……...❒ Yes ❒ No
    If yes, please describe._____
11. Check any of the following which apply in either past or present:

❒ Hot or Cold Sensitivity
❒ Sweets Sensitivity
❒ Biting or Chewing Sensitivity
❒ Experience bad odors or bad tastes
❒ Frequent cold sores, blisters or other lesions
❒ Bleeding gums
❒ Painful gums
❒ Experienced gum disease
❒ Have tooth loss
❒ Loose teeth
❒ Change in your bite
❒ Food catches between your teeth
❒ Clench or grind teeth while asleep
❒ Clench or grind teeth while awake
❒ Bite lips or cheek regularly
❒ Hold foreign objects with teeth (i.e. pencil)
❒ Mouth breathe while awake or asleep

❒ Snore or other sleeping disorders
❒ Use, smoke, chew tobacco
❒ Orthodontic treatment
❒ Oral Surgery
❒ Periodontal treatment
❒ Your teeth ground or bite adjusted
❒ Received a bite plate or mouth guard
❒ Clicking or popping of jaw
❒ Pain (joint, ear, side of face)
❒ Difficulty opening / closing mouth
❒ Difficulty chewing on either side of mouth
❒ Head, neck, or shoulder aches
❒ Sore muscles (neck, shoulder)
❒ A serious injury to the mouth or head?
If so, please describe, including cause_____
_____
❒ Experience tired jaws, especially in the morning

12. Are you satisfied with your teeth's appearance?…….……..... ❒ Yes ❒ No
13. Would you like to keep all of your teeth all of your life? ……..……..….❒ Yes ❒ No
14. Do you feel nervous about dental treatment? …… ……..……..…❒ Yes ❒ No
    If so, what is your biggest concern?_____
15. Have you ever had an upsetting dental experience? ……..……..….❒ Yes ❒ No
    Please describe. _____
16. Have you ever been told to take a pre-medication prior to dental treatment? ……..……..….❒ Yes ❒ No
17. Is there anything else you would like us to know? Please describe. _____
    _____
    _____