WILBUR FAMILY DENTISTRY
DANIEL B. FENN, D.D.S.

DENTAL HISTORY

Name _____ Nickname _____ Age _____

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

I typically see a dentist every: ☐ 3 Months ☐ 4 Months ☐ 6 Months ☐ 12 Months ☐ Not routinely

Is there anything in your mouth bothering you currently? _____

_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
Are you fearful of dental treatment? How fearful, on a scale of 1(least) to 10 (most)_____	☐	☐
Have you had an unfavorable dental experience?_____	☐	☐
Have you ever had complications from past dental treatment, that you feel we should know?_____	☐	☐
Have you ever had trouble getting numb or had any reactions to local anesthetic?_____	☐	☐
Have you ever had braces? If yes, at what age?_____	☐	☐
Have you had any teeth removed or missing teeth that never developed or were lost due to injury/trauma?_____	☐	☐
Do your gums bleed or are they painful when brushing or flossing?_____	☐	☐
Have you ever been treated for gum disease or been told that you have lost bone around your teeth?_____	☐	☐
Have you ever noticed an unpleasant taste or odor in your mouth?_____	☐	☐
Do you feel or notice holes (pitting, craters) on the biting surface of your teeth?_____	☐	☐
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?_____	☐	☐
Have you ever noticed broken teeth or chipped teeth/fillings? _____	☐	☐
Do you frequently get food caught between any teeth?_____	☐	☐
Do you have problems with your jaw joint, or notice yourself clenching your teeth? (pain, sounds, limited opening) _____	☐	☐
Do you avoid or have difficulty chewing gum, carrots, nuts, protein bars, or other hard, dry foods?_____	☐	☐
Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?_____	☐	☐
Do you notice yourself clenching your teeth during the day?_____	☐	☐
Have you been disappointed with the appearance of previous dental work?_____	☐	☐
Have you ever whitened (bleached) your teeth?_____	☐	☐
Is there anything about the appearance of your teeth that you would like to change? (shape, color, size)_____	☐	☐
Are you satisfied with the appearance of your smile?_____	☐	☐

Is there anything else we should know about your dental needs? _____

_____