Jill Shelton Wagers D.M.D.
FAMILY DENTISTRY

DENTAL HISTORY

What Is Your Immediate Dental Concern? _____

Previous Dentist _____ How Long? _____

Most Recent Dental Exam _____ Most Recent Dental X-Rays _____

Most Recent Dental Treatment _____

How Often Do You Have Your Teeth Cleaned? ❑ 3 months ❑ 4 months ❑ 6 months ❑ 1 year or longer

Please Check All That Apply.

A. Sensitivity: ❑ Hot ❑ Cold ❑ Pressure ❑ Sweets ❑ Root Surface ❑ Specific Teeth ❑ Generalized

Explain: _____

B. Previous **Orthodontic** Treatment (Braces) ❑ Yes ❑ No When? _____

C. Previous **Periodontal** (Gum) Treatment ❑ Yes ❑ No When? _____

D. Have you lost any permanent teeth? ❑ Yes ❑ No

Have you had any difficulty with extractions? ❑ Yes ❑ No

Have you ever had prolonged bleeding? ❑ Yes ❑ No

E. Do you have difficulty swallowing or gag easily? ❑ Yes ❑ No

F. Do you have dry mouth, throat, and/or eyes? ❑ Yes ❑ No

G. **Temperomandibular Joints**:

Do you experience: ❑ Clenching or Grinding of your teeth ❑ Discomfort when Chewing or in Joints ❑ Popping or Clicking ❑ Frequent Morning Headaches ❑ Locking Jaw ❑ Difficulty Opening Widely ❑ Wear a Bite Splint or Nightguard

H. How would you rate your anxiety level during dental treatment? ❑ Low ❑ Medium ❑ High

Unfavorable dental experiences? ❑ Yes ❑ No When? _____

Dental Fears? ❑ Yes ❑ No When? _____

Difficulty getting numb? ❑ Yes ❑ No When? _____

I. **Appearance**:

Are you pleased with the appearance of your teeth? ❑ Yes ❑ No

Are you interested in changing your smile? ❑ Yes ❑ No _____

Supplemental Denture History:

If you are wearing a partial or complete artificial denture, please complete the following:

1. Has your present denture been relined? ❑ Yes ❑ No When? _____
2. Is your present denture a problem? ❑ Yes ❑ No Describe _____
3. Are you satisfied with the appearance? ❑ Yes ❑ No Describe _____
4. Are you satisfied with the comfort? ❑ Yes ❑ No Describe _____
5. Are you satisfied with the chewing ability? ❑ Yes ❑ No Describe _____
6. When did you receive your first partial or complete denture? _____
7. How long have you worn your present denture? _____

Patient's Signature _____ Date _____

Doctor's Remarks: _____

Doctor's Signature: _____