Dr. Stephanie A. Vondrak
Dr. Ashley A. Rainbolt

[DENTAL HEALTH HISTORY]

What are your goals for today's appointment?_____
Do you have any immediate dental concerns or problems?_____
Date of last dental visit?_____ Last professional dental cleaning?_____
How often do you visit the dentist?_____
How often do you brush your teeth?_____ How often do you floss?_____

Have you ever had any of the following:

Oral surgery or teeth removed	__Yes __No
Periodontal deep cleanings	__Yes __No
Gum tissue pain or bleeding	__Yes __No
Root canal therapy	__Yes __No
Orthodontic treatment	__Yes __No

Are your teeth sensitive to:
____Hot ____Cold ____Sweets ____Biting or Chewing

Have you experienced:

Clicking or popping of the jaw	__Yes __No
Pain (joint, ear, side of your face)	__Yes __No
Difficulty opening or closing	__Yes __No
Headaches or neck/shoulder pain	__Yes __No
Any loose teeth or changes in bite	__Yes __No
Jaw fatigue or aching in the morning	__Yes __No
Injury or trauma of head or neck	__Yes __No

Have you ever had your *bite adjusted* or worn a corrective or protective appliance for clenching or grinding? __Yes __No Describe:_____

Do you have any of the following concerns?

Sleep apnea	__Yes __No
Frequent snoring	__Yes __No
Excessive daytime sleepiness	__Yes __No
Feeling unrefreshed in the morning	__Yes __No
Difficulty falling asleep	__Yes __No
Difficulty maintaining sleep	__Yes __No
Waking up gasping/choking	__Yes __No
Memory problems	__Yes __No
Difficulty breathing through the nose	__Yes __No

At Vondrak Dental we want you to feel completely comfortable during your visits with us. It is our mission to provide you with the most positive experience possible. Please let us know if you have experienced any stressful dental situations that you would like to avoid in the future.

_____
_____
_____.