Medical and Dental History

Date of last dental visit:

Date of last dental x-rays:

Have you had any of the following conditions? Check all that apply:

- ☐ Bad breath
- ☐ Food collection between teeth
- ☐ Swollen gums
- ☐ Mouth breathing
- ☐ Periodontal treatment
- ☐ Ear pain
- ☐ Growths in mouth
- ☐ Burning sensation on tongue
- ☐ Orthodontic treatment
- ☐ Bleeding gums
- ☐ Oral blisters
- ☐ Dry mouth
- ☐ Teeth grinding
- ☐ Popping or clicking jaw
- ☐ Sensitivity too hot/cold/pressure/sweets
- ☐ Lip/cheek biting

How often do you brush? Never Floss? Never

Physicians Name:

Physicians Phone:

Date of last visit:

Current medications:

Do you have any allergies? Check all that apply:

☐ Aspirin ☐ Latex ☐ Sulfa ☐ Iodine ☐ Shellfish ☐ Penicillin
☐ Barbiturates ☐ Codeine ☐ Local Anesthetic Other

Are you pregnant? Yes ◯ No ◯ If yes, how far along?
Are you taking birth control? Yes ◯ No ◯
Are you nursing? Yes ◯ No ◯

Do you smoke? Yes ◯ No ◯
Do you chew tobacco? Yes ◯ No ◯
Do you smoke marijuana? Yes ◯ No ◯
Do you vape or use electronic cigarettes? Yes ◯ No ◯