DENTAL HEALTH HISTORY

WHEN WAS YOUR LAST DENTAL EXAMINATION: _____LAST CLEANING_____

CHECK ALL THAT APPLY

__ TENDER GUMS WHILE CHEWING __ BLEEDING GUMS __ BAD BREATH __ SORE AREAS IN YOUR MOUTH

__ PAIN IN OR NEAR EARS __ SPACE DEVELOPING BETWEEN TEETH __ SENSITIVITY TO HOT, COLD, SWEETS ___ TOOTHACHE

HAVE YOU BEEN TREATED BY A PERIODONTIST (GUM SPECIALIST): YES OR NO ORTHO _____

ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH: YES OR NO IF NOT WHY:

_____

DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT: YES OR NO

ARE YOU CURRENTLY TAKING VITAMINS OR CBD PRODUCTS? _____

PREFERRED PHARMACY_____

HAVE YOU RECEIVED THE COVID-19 VACCINES?/ NONE /YES OR NO /

J AND J/ MODERNA/ PFIZER /

1ST Date_____ 2ND Date _____ BOOSTER Date_____

HAVE YOU HAD A JOINT REPLACEMENT OR HEART VALVE REPLACEMENT / YES OR NO

HOME CARE

HOW OFTEN DO YOU BRUSH YOUR TEETH: _____FLOSS_____

WHAT KIND OF BRUSH DO YOU USE: __ MANUAL __ ELECTRIC

WHAT TEXTURE OF BRUSH DO YOU USE: __ SOFT __ MEDIUM __ HARD

DO YOU SUFFER FROM MIGRAINES: YES OR NO DO YOU SNORE?_____

TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE INFORMATION IS CORRECT. I WILL INFORM YOU IF ANY CHANGES IN MY HEALTH OR MEDICATIONS SHOULD OCCUR.

SIGNATURE: _____ DATE: _____