Smoking and Oral Health History Form

Full Name	
Date of Birth	
Gender	
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Do you currently smoke?	
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If yes/former, how many years have you smoked?	
Average number of cigarettes per day	
If former smoker, year you quit	
Do you use other tobacco products?	
Do you have any of the following?	
Date of last dental checkup	
Date of last defical checkup	
Family history of gum disease or oral cancer?	_
Additional Comments	
Additional Commonto	