Oral Health Risk Factors

Patient's Name: _____

1. Do you smoke or have you EVER smoked? £ Yes £ No

(If No, proceed to question 2)

The amount that you are presently smoking (Check ALL that apply)

___None (quit smoking completely) ___Less than 1 pack of cigarettes per day ___An occasional cigar
___An occasional cigarette ___1-2 Packs of cigarettes per day ___Cigars on a daily / regular basis
___A few cigarettes per Day ___2 or more packs of cigarettes per day ___Occasional pipe smoker
___A pipe on a daily / regular Basis

If you have quit smoking, when did you quit?

___Less than 6 months ago ___6 months to a year ago ___1 to 3 years ago ___Over 3 years ago

How many years have you or did you smoke?

___Less than 2 years ___2-5 years ___5-10 years ___10-20 years ___Over 20 years

2. Do you / Have you EVER chew/chewed tobacco or use/used snuff or other similar substance? £ Yes £ No

(If No, proceed to question 3)

Are you STILL using smokeless tobacco or snuff? £ Yes £ No

If No, WHEN did you quit?

___Less than 6 months ago ___6 months to a year ago ___1 to 3 years Ago ___Over 3 years ago

How many years did you use or have you used smokeless tobacco?

___Less than 1 year ___1-2 years ___2-5 years ___Over 5 years

3. Approximate average amount of alcoholic beverages presently consumed per week:

___None ___Less than 1 per week ___1-5 drinks ___6-11 drinks ___11-20 drinks ___Over 20 drinks

4. Do you have or have you ever had a substance abuse problem? £ Yes £ No

Describe_____

5. Do you presently use any recreational drugs? £ Yes £ No

List_____

6. Do you have or have you ever had an eating disorder? £ Yes £ No

If Yes, Please Specify: _____

7. Do you have or have you ever had any head, neck or mouth piercing(s)? (Other than ears) £ Yes £ No

List _____

8. Do you have or have you ever been informed that you have been infected with an oncogenic strain (possible cancer-causing) of the Human Papilloma Virus (HPV)? £ Yes £ No

9. Please list your history or any family member's history of cancer:

_____

_____

10. Other concerns and considerations:

_____

_____

CONSENT—To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care

Signature_____ Date _____

(Parent or guardian, if patient is a minor)

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Reviewed By: _____