

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 a 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 stuff?

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 years 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. Approximate average amount of soda/sugary drinks do you presently consume per week? _____

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

Describe _____

6. Do you presently use any recreational drug? Yes No

List _____

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

If Yes, Please Specify: _____

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

Describe _____

9. 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

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

11. Other concerns and considerations:

CONSENT – To the best of my knowledge, all 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)

Reviewed By: _____