

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)

- | | | |
|---|---|--|
| <input type="checkbox"/> None (quit smoking completely) | <input type="checkbox"/> Less than 1 pack of cigarettes per day | <input type="checkbox"/> An occasional cigar |
| <input type="checkbox"/> An occasional cigarette | <input type="checkbox"/> 1-2 Packs of cigarettes per day | <input type="checkbox"/> Cigars on a daily / regular basis |
| <input type="checkbox"/> A few cigarettes per Day | <input type="checkbox"/> 2 or more packs of cigarettes per day | <input type="checkbox"/> Occasional pipe smoker |
| | | <input type="checkbox"/> 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)