

# Oral Health Risk Factors

Patient's Name \_\_\_\_\_

**1. Do you smoke or have you EVER smoked?**

(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       A pipe on daily/regular basis

**If you have quit smoking, when did you quit?**

- Less than 6 months ago     6 months to a year ago     1-3 years ago     over 20 years

**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     1-3 years Ago     Over 3 years ago

**How many years did you see 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 Papillomavirus (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)

Reviewed By: \_\_\_\_\_

