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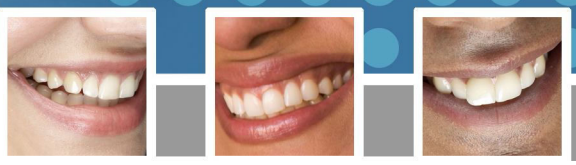

Oral Health Risk Factors

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)
☐ An occasional cigarette
☐ A few cigarettes a day
☐ Less than 1 pack of cigarettes per day
☐ 1-2 packs of cigarettes per day
☐ 2 or more packs of cigarettes per day
☐ An occasional cigar
☐ Cigars on a daily/regular basis
☐ An occasional pipe
☐ A pipe on a daily/regular basis

If you 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) smoked?

◯ Less than 2 years ◯ 2-5 years ◯ 5-10 years ◯ 10-20 years ◯ Over 20 years

2. Have you EVER chewed tobacco or used snuff or similar substances? ☐ 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 have you (or did 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 ◯ 5-11 drinks ◯ 11-20 drinks ◯ Over 20 drinks

4. Have you ever had a substance abuse problem? ☐ Yes ☐ No

If yes, please describe _____

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

If yes, please list _____

6. Have you ever had an eating disorder? ☐ Yes ☐ No

If yes, please specify _____

7. Have you ever had any head, neck, or mouth piercings? (Other than ears) ☐ Yes ☐ No

If yes, please list _____

8. Have you ever been informed that you have been infected with an oncongenic 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 and healthcare provider(s) and to have the patients 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 _____