

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)