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 1year __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:_____

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