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) Reviewed By: ____________________

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