

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 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: _____

Signature _____ Date _____

(Parent or guardian, if patient is a minor)

Reviewed By: _____