Dr. Jeffrey P Fish DDS * 107 West Main Street * Crosby, MN 56441 * 218/546-6031

ORAL HEALTH RISK FACTORS

Your honest responses to these questions will help assess your risk for serious oral disease, including cancer. All responses are confidential and will only be used in determining a diagnosis and/or oral health plan.

Patient's Name: _____

☐ Yes ☐ No **1. Have you EVER smoked cigarettes?** (if no, proceed to question 2)

The amount that you are presently smoking (check all that apply)

☐ None (quit smoking completely) ☐ >1 pack of cigarettes/day ☐ An occasional cigar
☐ An occasional cigarette ☐ 1-2 packs of cigarettes/day ☐ Cigars on a daily/regular basis
☐ A few cigarettes per day ☐ 2 or more packs of cigarettes/day ☐ Occasional pipe smoker
☐ A pipe on a daily/regular basis

If you have quit smoking, when did you quit?

☐ >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?

☐ > 2 years ☐ 2-5 years ☐ 5-10 years ☐ 10-20 years ☐ Over 20 years

☐ Yes ☐ No **2. Have you ever chewed tobacco, used snuff or other similar substance?** (If no, proceed to question 3)

☐ Yes ☐ No **Are you still using smokeless tobacco or snuff?**

If no, when did you quit?

☐ >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 use chewing tobacco/snuff/etc?

☐ > 1 year ☐ 1-2 years ☐ 2-5 years ☐ Over 5 years

☐ Yes ☐ No **3. Do you consume alcoholic beverages?** (if no, proceed to question 4)

Approximate average amount of alcoholic beverages presently consumed/week:

☐ None ☐ > 1/week ☐ 1-5 drinks ☐ 6-11 drinks ☐ 11-20 drinks ☐ over 20 drinks

☐ Yes ☐ No **4. Do you have or have you ever had a substance abuse problem?**
(If yes, please describe): _____

☐ Yes ☐ No **5. Do you presently use recreational drugs?**
(If yes, please list): _____

☐ Yes ☐ No **6. Do you have or have you ever had an eating disorder?**
(If yes, please describe): _____

☐ Yes ☐ No **7. Do you have or have you ever had any head, neck or mouth piercing(s)?** (Other than ears)
(If yes, please describe): _____

☐ Yes ☐ No **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)?**

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 patier health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care

_____ ___/___/_____ _____ ___/___/____

Patient or guardian signature **Date** **Jeff P Fish DDS staff signature** **Date**