Risk Assessment Questionnaire

.....(ages 14 and up).....

Name: _____ **Date:_____**

Dental Concerns (teeth, gums or jaw health):_____

_____

Dental History:

Orthodontics: No☐ or Yes☐ N/A☐ if yes, Year: _____

Wisdom Teeth Extracted: No☐ or Yes☐ if out, Approx. Year: _____ Unsure_____

Last Cleaning (approx.): _____ Last x-rays: _____

Home Care Routine:

Brushing frequency: _____ Manual☐ Electric☐

Flossing/Interproximal cleaning frequency: _____

Products(ex: manual floss, picks, etc.): _____

Other: (mouth wash, waterpik, etc.) _____

Fluoride exposure (ex: toothpaste, rinses, supplements, water): _____

Nutritional Information: Frequent Snacker? No☐ or Yes☐ if yes, what kind of snacks (ex: soda, coffee, milk, water, tea, juice, crackers, carbs, fruits, veggies): _____

Tobacco Use: No☐ or Yes☐ If yes, how often _____

Alcohol: No☐ or Yes☐ If yes, how often _____

Dry Mouth: No☐ or Yes☐ If yes, what helps _____

Acid Reflux: No☐ or Yes☐ If yes, what helps _____

Family History:

If yes, list yourself or any family member(s)

Heart Disease/Condition: No☐ or Yes☐_____

Diabetes: Type: 1 or 2 No☐ or Yes☐ _____

Cancer: No☐ or Yes☐ _____Type: _____

Periodontal/ Gum Disease: No☐ or Yes☐_____

How is your immune system? (How many times a year do you get cold/flu):_____