Dental RISK Analysis and History

Name: _____ **Date:** _____

1. What are your dental needs, concerns, or experiences as of now? Please describe:

_____
_____
_____
_____
_____

2. Please circle the correct answer if you: Smoke Chew **Tobacco** Dip snuff
If yes to any of the above: How many years?: _____
If cigarettes, how many packs per day?: _____
Where in your mouth do you place the cigar/cigarette/pipe?: _____
Where in your mouth do you place the tobacco or snuff?: _____

3. Do you drink **alcohol**? Daily Weekly Occasionally

4. Do you play **sports**? If yes, what sport(s): _____
Do you wear a sportsguard/mouthpiece? _____

5. Have you ever had any accidents, injury or **trauma** to your teeth, mouth or face? Y N
Details: _____
_____
_____

6. Do you sip on sodas(diet or regular), sports **drinks**, energy drinks, coffee, sweet tea, juices?:
_____

7. Do you wake up with sore **muscles**, or grind or clench your teeth at night? Y N

8. Do you have a **dry mouth**? No Occasional Mild Moderate Severe
If yes, how long: _____

9. Do you **snack** or suck on candy, mints, cough drops? **Y N**
If yes, when and what: _____
_____

10. Have you ever had any **problems** after having a tooth pulled? (Bleeding? Joint pain?) Y N

11. Have you **ever had** any of the following? (please **check** all that apply)

__ TMJ/Bite treatment __ Gum Treatment __Surgery __Braces __Other

12. Do you **floss**? __ Every Day __Every Week __Occasionally __Never

13. Do you **brush** your teeth? __After Breakfast __After Lunch __After Dinner

__Before Breakfast __Before Bedtime __ Not daily

14. What kind of **toothbrush** do you use? __ Sonicare __ Braun __Electric (other) __ Manual

15. What **advice** would you give us about you? _____
_____