Dental History and Risk Assessment Form

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Name Date of Birth

What are your current dental concerns?

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Date of last dental visit?____________ Date of last dental cleaning?____________________

Please answer the following questions to the best of your ability. Our Oral Health team uses this information as part of an individual assessment to help determine your risk of cavities and gum disease. We also use this information to customize a plan for your needs.

	Yes	No	Explain
Do you have any of the following conditions?			
• Dental Pain			
• Bleeding gums			
• Tooth sensitivity			
• Unpleasant taste or mouth odor			
• Head, neck or shoulder pain			
• Numbness, tingling, burning sensation in the head and neck			
• Jaw pain			
Do you grind or clench your teeth?			
Do you wear any appliances or prostheses like nightguards, retainers or dentures?			
Do you have fluoride in your drinking water?			
Do you use a fluoride toothpaste, mouthrinse or prescription product?			
Have you used xylitol products more than 4 times/day for the last 6 months?			
Have you used a prescription mouthrinse (Chlorhexidine/Peridex) in the last 6 months?			
Have you used a calcium phosphate toothpaste (MI Paste) in the last 6 months?			

	Yes	No	Explain
Have you ever taken a premedication for dental appointments?			
Have you had a major change in health in the past year (heart attack, stroke etc.)?			
Have you ever had chemotherapy/radiation?			
Have you ever had oral cancer?			
Have you ever taken a bone loss prevention medication or bisphosphonate (ex. Fosamax, Boniva, Actonel)?			
Are you pregnant or breastfeeding?			
Do you have diabetes?			
• Do you know your last HbA1c value?			
Have you ever had an eating disorder?			
Have you ever had acid reflux (GERD)?			
Do you take any blood thinners?			
• Which blood thinners?			
• If you take Coumadin/Warfarin, do you know your last INR?			
Do you currently use recreational drugs?			
Have you ever used recreational drugs?			
Have you ever smoked cigarettes, cigars or pipes?			
• How many packs/day?			
• How many years?			
• Have you quit? How long ago?			
Have you ever used smokeless tobacco products?			
• Do you use smokeless tobacco daily?			
• How many years?			
• Have you quit? How long ago?			
Do you drink alcohol?			
• How many drinks per day?			
Do you have sugar containing snacks more than 4 times/day?			
Do you have dry mouth?			
Have you ever had periodontal surgery?			

Please be advised that the weight capacity for the dental chairs is 300lbs. If your weight exceeds that limit please inform a member of the staff so that alternative arrangements can be discussed.

How did you hear about the MSHC dental clinic? ____