East Cooper Smiles

NAME:_____

DATE:_____

RISK ASSESSMENT

	YES	NO
1. Have you been to the dentist in the last 2 years?		
2. Do you use tobacco products?		
3. Do you have diabetes?		
4. Is there a family history of diabetes?		
5. Do you have cardiovascular disease?		
6. Do you have family history of high blood pressure (hypertension)?		
7. Have you have treatment for periodontal disease?		
8. Do you have family history of periodontal disease?		
9. Do you have family history of cancer?		
10. Do you have osteoporosis?		
11. Do you have dry mouth (Xerostemia)?		
12. Are you under stress?		
13. Does your doctor have you take antibiotics before dental appointments?		
14. So you have any artificial replacements?		
15. Do your gums bleed?		
16. Do you have bad breath?		
17. Do you floss?		
18. How often do you floss?		
19. Have you had any adult teeth extracted?		
20. Do you have any habits? (example: sucking thumb, chewing ice, cough drops, etc.)		

21. Please share what would help to make your dental experience a positive one:

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