Name _____ Date_____

Help us get to know you better

1) Do you notice plaque build-up on your teeth between brushings? No Yes

2) Do You take medications daily? No Yes If yes, how many (#____) if yes, please list medication (s) you are taking.

_____ dosage_____ frequency_____

_____ dosage_____ frequency_____

_____ dosage_____ frequency_____

3) Do you feel like you have a dry mouth at any time of the day or night? No Yes

If yes, what helps relieve your dry mouth? Ex: water, mints, biotene _____

4) Do you drink liquids other than water, more than 2 times daily between meals? No Yes

If yes, please give examples ex. Coffee w/cream & sugar, soft drinks, sports drinks, tea juice, wine, beer etc.

5) Do you snack between meals? No Yes If yes, please give ex: chips, candy, fruit, nuts
_____

6) Do you have oral appliances? (nightguard, orthodontic retainers, dentures, partial) No Yes

7) Do you smoke? No Yes If yes, how much per day_____

8) Are you diabetic? No Yes If yes, how do you control your diabetes?_____

9) Do you experience Acid Reflux? No Yes

If yes, do you take medication to control it, if so please list _____

10) Have you had head/neck radiation therapy? No Yes if yes, when/why_____

11) Do you suffer from Bulimia? No Yes

12) Do you suffer from Sjogren's syndrome? No yes

13) Do you use other street drugs? No Yes if yes, please list _____

_____ For office use Only _____

Low Risk	Moderate Risk	High Risk	Extreme Risk
1	2	3	4