Periodontal Risk Assessment Questionnaire

I. Tobacco Use – Tobacco use is the most significant risk factor for gum disease. Do you now or have you ever used the following:

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<th>Amounts / Day</th>
<th>Years of Use</th>
<th>Year you quit</th>
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<td>Cigarettes</td>
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<td>Cigars</td>
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<td>Pipe</td>
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<td>Chewing</td>
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II. Diabetes – Gum Disease is a common complication associated with diabetes. Untreated gum disease makes it harder for patients with diabetes to control their blood sugar.

IF YOU ARE A PATIENT WHO HAS DIABETES:
Is your diabetes under control? _____Yes _____No
Are you prone to diabetic complications? _____Yes _____No
How do you monitor your blood sugar? ___________________________________________
Who is your physician for diabetes? _____________________________________________

IF YOU ARE NOT A PATIENT WHO HAS DIABETES:
Do you have a family history of diabetes? _____Yes _____No
Have you had any of the following warning signs of diabetes?
___Frequent urination ___Excessive thirst
___Excessive hunger ___Weakness and fatigue
___Slow healing of wounds ___Unexplained weight loss

III. Heart Attack / Stroke – Untreated gum disease may increase your risk for hear attack or stroke.
Do you have any risk factors for heart disease or stroke?
___Tobacco Use ___Obesity
___High Cholesterol ___High blood pressure
___Family history of heart disease

IV. Medications – A side effect of some medications can cause changes in your gums.
Are you taking or have you ever taken any of the following medications:

___Antiseizure medications. (i.e., Dilantin®, Tegretol®, Phenobarbital, etc.)
   If you answered yes, are you still taking the anti-seizure medication? _____Yes _____No
   Other medication: ___________________________________________
___Calcium Channel Blocker blood pressure medications. (i.e., Procardia®, Cardizem®, Norvasc®, Verapamil®, etc.)
   Other medication: ___________________________________________
___Immunosuppressant therapy (i.e., Prednisone, Azathioprine, Cyclosporins, Corticosteroids, (Asthma-Inhalers), etc.)
   Other medication: ___________________________________________

V. Family History / Genetics – Is there an immediate family member(s) who currently has or had gum problems in the past? (i.e., your mother, father or siblings):
___Yes _____No
VI. Heart Murmur / Artificial Joints or Prosthesis – If you have even the slightest amount of gum inflammation, bacteria from the mouth can enter the bloodstream and may cause a serious infection of the heart or joints.

Do you have a heart murmur or artificial joints?  
_____Yes  _____No

If yes, does your physician recommend antibiotics prior to dental visits?  
_____Yes  _____No

Name of physician: ________________________________

*If you answered yes, it is especially important to always keep your gums as healthy and inflammation-free as possible to reduce the chance of bacterial infection originating from the mouth.

VII. Females – Females can be at increased risk for gum disease at different points in their lives.

The following factors can adversely affect your gums. Please check all that apply:

_____Pregnant  _____Nursing  
_____Menopause  _____Taking birth control pills  
_____Infrequent care during previous pregnancies

Women with osteoporosis have a greater risk for periodontal bone loss.

Do you take any of the following:

_____Estrogen Replacement Therapy / Hormone Replacement Therapy (i.e., Prempro ®, Premarin ®, Premphase ®, Fosamax ® Actonel ®, Evista ®, Forteo ®, etc.)

Other(s): ________________________________

IX. Stress - High levels of stress can reduce your body’s immune defense.

Are you under a lot of stress?  
_____Yes  _____No

IX. Nutrition – Your diet has the potential to affect your periodontal health.

Do you find it difficult to maintain a well-balanced diet?  
_____Yes  _____No

Please complete the following:

Have you noticed any of the following signs of gum disease?

_____Bleeding gums during toothbrushing  _____Pus between the teeth and gums
_____Red, swollen or tender gums  _____Loose or separating teeth
_____Gums that have pulled away from the teeth  _____Persistent bad breath
_____Change in the way your teeth fit together  _____Food catching between teeth

Is it important to keep your teeth for as long as possible?  
_____Yes  _____Not really

If you have missing teeth, why have you not had them replaced? ____________________________________________

Do you like the appearance of your smile?  
_____Yes  _____No
Do you like the color of your teeth?  
_____Yes  _____No
Do your teeth keep you from eating any specific foods?  
_____Yes  _____No

Patient Name: ________________________________  Date: _____/_____/_____