	Alcohol Consumption ☐ Never had more than 12 drinks in any year of my life ☐ I've had more than 12 drinks in one year, but not in the past year. ☐ I've had more than 12 drinks in the past year, and less than 3 drinks a week ☐ I've had 3 to 14 drinks per week on average in the past year ☐ I have 2-3 drinks per day for the past year ☐ I have more than 3 drinks per day in the past year.		
Other	**Do you have a pierced tongue or oral habit (eating ice, playing musical instrument with mouthpiece, opening bottles) that places excessive stress on your teeth?**	☐ Yes	☐ No

Cosmetics	Are you satisfied with the color of your teeth?	☐ Yes	☐ No
	Are you satisfied with the alignment of your teeth (how straight they are?)	☐ Yes	☐ No
	Are you satisfied with the spacing of your teeth?	☐ Yes	☐ No
	Are you interested in whitening treatments?	☐ Yes	☐ No
Sores	Do you have or have you ever had any swelling in your mouth or gums?	☐ Yes	☐ No
	Do you suffer with fever blisters? If so, how long do they last? _____	☐ Yes	☐ No
	Do you suffer from ulcers? If so, how long do they last? _____	☐ Yes	☐ No
	Does your tongue itch or burn?	☐ Yes	☐ No
	Do you bite your cheek?	☐ Yes	☐ No

ORAL HYGEINE

How many times a day do you brush your teeth_____ How many times a day do you floss? _____		
How often do you change your toothbrush? _____		
What is the texture of your toothbrush (select one)? ☐Soft ☐Medium ☐ Hard		
What type of toothbrush do you use (select one)? ☐ Manual ☐Electric		
Do you brush your tongue?	☐ Yes	☐ No
Do you chew gum? If yes, write the brand that you chew most often?_____	☐ Yes	☐ No
Do you use mouthwash? If yes, which brand?_____	☐ Yes	☐ No
Who supplies your household drinking water (select one)? ☐Municipality (city, county) ☐ We use well-water		
If you use well-water, do you add fluoride?	☐ Yes	☐ No
What brand of toothpaste do you use?	☐ Yes	☐ No
Do you suffer from persistent bad breath (halitosis)?	☐ Yes	☐ No

OTHER QUESTIONS

☐	Radiation therapy to the head or neck
☐	Blood Thinners
☐	GERD (acid reflux)
☐	Injury or trauma to the mouth, face or jaws
☐	Boniva or treatment for osteoporosis?
☐	Do you take vitamins?
☐	Have you had a major change in heath (heart attack, stroke, etc) during the past 12 months?

Are you a Diabetic?

☐ Unknown
☐ Not Diabetic
☐ Good diabetic control
☐ Fair Diabetic Control
☐ Poor Diabetic Control

Cancer History

Have you ever had:	**Has your parent or sibling ever had?**
☐ Breast	☐ Breast
☐ Colon or rectum	☐ Colon or rectum
☐ Lung and Bronchus	☐ Lung and Bronchus
☐ Oral cavity	☐ Oral cavity
☐ Prostate	☐ Prostate
☐ Skin	☐ Skin
☐ Urinary bladder	☐ Urinary bladder
☐ Uterine	☐ Uterine
☐ Other	☐ Other
☐ None	☐ None