

Gum Disease Risk Assessment



Patient Information

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient First Name	MI	Patient Last Name	Patient Date of Birth

General Health Information

In our practice, we strive to provide our patients with optimal oral health. We are focused on preventing or limiting periodontal (gum) disease, and dedicated to identifying and treating disease early, when the pain and costs associated with treatment are much less. According to the National Center for Biotechnology Information, "Significant associations between periodontal disease and cardiovascular disease, diabetes mellitus, preterm low birth weight, and osteoporosis have been discovered, bridging the once-wide gap between medicine and dentistry." Please take a few minutes to answer the questions below so that we can assess your individual risk for gum disease and tailor our treatment recommendations to your specific needs.

<input type="text"/> Do you floss daily? <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> Are you age 35 or older? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="text"/> Do you have a family history of premature adult tooth loss and/or gum disease? <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> Do you have a history of heart disease and/or are you taking medication for hypertension? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="text"/> Are you taking medication for diabetes? <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> Have you ever been a tobacco user (including smokeless tobacco) and/or smoker of any kind (including marijuana/vape)? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="text"/> Is there redness on toothbrush or in the sink when you rinse after brushing? <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> Do you have persistent bad breath (noticed by you, your partner/friend/colleague)? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="text"/> Have you noticed a movement/shifting of teeth (gaps developing, tooth/teeth mobility)? <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="text"/> Do you occasionally experience discomfort/pain when eating/chewing? <input type="checkbox"/> Y <input type="checkbox"/> N

TOTAL POINTS

Assessing your Gum Disease Risk

LOW TO MODERATE RISK: Total Points 0-3

MODERATE TO HIGH RISK: Total Points 4-9

HIGH RISK: Total Points 10 or higher

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient's Signature	Date	Doctor's Signature	Date