

Periodontal
Risk
Assessment

Printed name: \_\_\_\_\_  
 Student Name: \_\_\_\_\_  
 Date: Click here to enter a date

Do you measure how your teeth are wearing?

|                                      | Amount per day           | For how many years       | If you spit what you?    |
|--------------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> 1-2 times   | Click here to enter text | Click here to enter text | Click here to enter text |
| <input type="checkbox"/> 3-4 times   | Click here to enter text | Click here to enter text | Click here to enter text |
| <input type="checkbox"/> 5-6 times   | Click here to enter text | Click here to enter text | Click here to enter text |
| <input type="checkbox"/> 7-8 times   | Click here to enter text | Click here to enter text | Click here to enter text |
| <input type="checkbox"/> 9-10 times  | Click here to enter text | Click here to enter text | Click here to enter text |
| <input type="checkbox"/> 11-12 times | Click here to enter text | Click here to enter text | Click here to enter text |
| <input type="checkbox"/> 13-14 times | Click here to enter text | Click here to enter text | Click here to enter text |
| <input type="checkbox"/> 15-16 times | Click here to enter text | Click here to enter text | Click here to enter text |
| <input type="checkbox"/> 17-18 times | Click here to enter text | Click here to enter text | Click here to enter text |
| <input type="checkbox"/> 19-20 times | Click here to enter text | Click here to enter text | Click here to enter text |

Do you have any other risk factors for heart disease or stroke?

☐ High cholesterol ☐ High blood pressure ☐ High blood sugar ☐ High blood pressure

Have you ever taken any of the following medications? ☐ Diuretics such as furosemide

☐ Calcium Channel Blockers such as amlodipine ☐ Thrombolytic agents such as alteplase

Has anyone on your side of the family had gum problems (e.g. your mother, father, siblings)?

☐ Yes ☐ No

Has anyone in your immediate family been treated with antibiotics for gum disease? If so, whom?

☐ Grandpa ☐ Grandma

The following questions already affect your gums. Please check all that apply.

☐ Frequent ☐ Sore ☐ Swollen ☐ Tearing ☐ Tearing ☐ Tearing

☐ Taking antibiotics ☐ Taking antibiotics ☐ Taking antibiotics

**IF YOU ARE DIABETIC, please answer H2C1.**

How is your diabetes controlled? ☐ Type 1 ☐ Type 2 ☐ Type 3 ☐ Type 4 ☐ Type 5

How do you monitor your blood sugar? ☐ Click here to enter text

Has anyone in your family ever had diabetes? ☐ Yes ☐ No

**IF YOU ARE NOT DIABETIC, please answer H2C2.**

Have you had any of the following signs of diabetes?

☐ Increased urination ☐ Increased thirst ☐ Increased weight loss

☐ Increased hunger ☐ Increased fatigue ☐ Increased thirst

**DO YOU HAVE A HISTORY OF ORAL DYSPLASIA?** ☐ Yes ☐ No

Has anyone in your family ever had oral dysplasia? ☐ Yes ☐ No

**WAS YOU EVER BEEN TREATED FOR GUM DISEASE?** ☐ Yes ☐ No ☐ Yes ☐ No

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

☐ Bleeding gums during brushing ☐ Pain between the teeth and gums

☐ Redness or swelling of the gums ☐ Bad breath or morning breath

☐ Loose or wiggling teeth ☐ Pain or swelling around the teeth

☐ Receding gums ☐ Changes in the way you bite together

Is it important to you to have your teeth as long as possible? ☐ Yes ☐ No, really

Are there any particular reasons why having them last may not be important?

Click here to enter text

Based on your assessment of the information gathered this form, please indicate the **PERIODONTAL RISK** level.

LOW ☐ MODERATE ☐ HIGH ☐

# ORAL SYSTEMIC LINK

- Direct Correlation:
  - Alzheimer's
  - Heart Disease
  - Diabetes
  - Adverse Pregnancy Outcomes
  - GI
  - Aspiration Pneumonia
  - Rheumatoid Arthritis