

ASSESSING THE RISK OF YOUR CHILD (Ages 0 – 5) FOR DENTAL DECAY

Child's name _____ Date of Birth _____ Date _____

HEALTH HISTORY

Yes No

Did the birthmother have any problems during pregnancy?

Was the child's birth weight low?

If yes, how much did he/she weigh? _____

Were there any complications at birth? _____

Has your child had any chronic or repeated illnesses? _____

Has your child taken any medications periodically or for long periods of time? _____

DIET AND NUTRITION

Is/was your child breastfed?

If so, does your child breastfeed frequently during the day?

Does your child fall to sleep while breastfeeding?

Does your child sleep with a bottle?

Does your child drink from a cup?

Is your child on a special diet?

If yes, please explain: _____

Do you give juices or other sugary drinks to your child more than two times a day?

Does your child eat three or more snacks a day?

Do you regularly pre-taste or pre-chew your child's food?

Do you regularly share kitchen utensils, orally clean a pacifier or a bottle nipple? ..

What type of snacks do you give to your child? _____

FLUORIDE ADEQUACY

Do you give tap water to your child?

Do you use a water conditioner or filtration system?

If yes, what type of filtration system? _____

Do you give bottled water to your child?

Does the bottled water contain fluoride?

Does your child take fluoride supplements?

If yes, please list: _____

Do you use fluoridated toothpaste for your child?

If yes, how much toothpaste do you use at each brushing: ● ○ ○

ORAL HYGIENE

How old was your child when the first tooth erupted? _____

Do you clean your child's gums / tongue

Do you use a toothbrush to clean your child's teeth?

How many times a day do you brush for your child? _____

Do you floss your child's teeth?

FAMILY HISTORY

Have the parents or caregivers had cavities treated recently?

When was the last dental visit for parents or caregivers? _____

Has either parent had gum disease? (bleeding gums).....

Does the patient have a brother or sister with cavities?

Doctor's comments: _____

ASSESSING THE RISK OF YOUR CHILD (Ages >6) FOR DENTAL DECAY

Child's name _____ Date of Birth _____ Date _____

HEALTH HISTORY

Yes **No**

Did the birthmother have any problems during pregnancy?

Was the child's birth weight low?

If yes, how much did he/she weigh? _____

Were there any complications at birth? _____

Has your child had any chronic or repeated illnesses? _____

Has your child taken any medications periodically or for long periods of time? _____

DIET AND NUTRITION

Is your child on a special diet?

If yes, please explain: _____

Do you give juices or other sugary drinks to your child more than two times a day?

Does your child eat three or more snacks a day?

Do you regularly share kitchen utensils?

What type of snacks do you give to your child? _____

FLUORIDE ADEQUACY

Do you give tap water to your child?

Do you use a water conditioner or filtration system?

If yes, what type of filtration system? _____

Do you give bottled water to your child?

Does the bottled water contain fluoride?

Does your child use a mouthwash?

If yes, please list: _____

Does your child use fluoridated toothpaste?

ORAL HYGIENE

How old was your child when the first tooth erupted? _____

How many times a day does your child brush his/her teeth? _____

Do you help him/her to brush?

Does your child use dental floss?

How often does he/she use dental floss? _____

Do you help him/her to floss?

FAMILY HISTORY

Have the parents or caregivers had cavities treated recently?

When was the last dental visit for parents or caregivers? _____

Has either parent had gum disease? (bleeding gums).

Does the patient have a brother or sister with cavities?

Doctor's comments: _____