Piedmont Pediatric Dentistry
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DENTAL DECAY RISK ASSESSMENT FOR AGES 6 AND UP

| DOB:

Health History

Patient Name	
Date of Birth	
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, 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?	

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 cavaties?	

Patient's signature: Date: