

Dental Risk Assessment Questionnaire



Parents and caregivers – use this form to tell us about the oral health of your child. This will be part of your child’s health record.

Parent/Guardian Name _____

Date _____

Child’s Name _____

Child’s Age _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Does your family drink water with fluoride in it or do your children take fluoride tablets? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does your child use a toothpaste with fluoride in it? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you help your child with toothbrushing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you or your children ever had a bad dental experience? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have any of your children ever had cavities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does your child complain of mouth pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does your child take a bottle to bed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your child walk around drinking from a bottle or cup? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. How many times does your child eat a snack each day? _____ | | |
| 10. How many bottles does your child have each day? _____ | | |
| 11. How is your own dental health? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor | | |
| 12. Do you have any cavities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do your gums bleed? | <input type="checkbox"/> | <input type="checkbox"/> |

Did you know?

For every 100 school children, more than 5 days of school per year are lost due to dental disease.

Good dental health is important!

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)



Oral Health Questionnaire

Child's Name _____

Date _____

Child's Age _____

Child's Date of Birth _____

HEALTH HISTORY

	Yes	No
Did the birth mother have any problems during pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child premature?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child's birth weight low?	<input type="checkbox"/>	<input type="checkbox"/>
Were there any complications at birth?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child been ill?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child on any medications?	<input type="checkbox"/>	<input type="checkbox"/>

DIET AND NUTRITION

Is/was your child breastfed?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child sleep with a bottle?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child drink from a cup?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child walk around drinking from a bottle or cup?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child on a special diet?	<input type="checkbox"/>	<input type="checkbox"/>
How many times does your child snack each day? _____		
How many bottles does your child have each day? _____		

FLUORIDE ADEQUACY

Do you know the fluoride level of your water?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have well water?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use bottled water?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a water conditioner or filtration system?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list _____		
Do you use fluoride toothpaste for your child?	<input type="checkbox"/>	<input type="checkbox"/>

ORAL HABITS

Does your child use a pacifier?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child suck a thumb or fingers?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child grind his/her teeth day or night?	<input type="checkbox"/>	<input type="checkbox"/>

INJURY PREVENTION

Is your child walking?	<input type="checkbox"/>	<input type="checkbox"/>
Is your home childproofed?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a car seat for your child?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child had an injury to his/her mouth or face?	<input type="checkbox"/>	<input type="checkbox"/>

ORAL DEVELOPMENT

Does your child have any teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Child's age (in months) when the first tooth came in? _____		
Has your child had teething problems?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any problems with your child's mouth or teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child complain of mouth pain?	<input type="checkbox"/>	<input type="checkbox"/>
Have any of your children ever had cavities?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or your children ever had a bad dental experience?	<input type="checkbox"/>	<input type="checkbox"/>

ORAL HYGIENE

Do you clean your child's gums/teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a toothbrush to clean your child's teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use toothpaste to clean your child's teeth?	<input type="checkbox"/>	<input type="checkbox"/>

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)



First Dental Home Visit Documentation

Patient's Name: _____

Age (in months): _____

Date of Visit: _____

Parent/Guardian at Appointment: _____

Visit Component	✓	Comments/Observations
Review of Health History		
Review of Dental History		
Oral Health of Primary Caregiver		
Oral Evaluation		
Caries Risk Assessment		
Toothbrush Prophylaxis or Prophylaxis		
Oral Hygiene Instruction with parent/caregiver		
Anticipatory Guidance		
❖ Oral Health and Home Care		
❖ Oral Health of Primary Caregiver/Other Family Members		
❖ Development of mouth/teeth		
❖ Oral Habits		
❖ Diet/Nutrition		
❖ Fluoride Needs		
❖ Injury Prevention		
❖ Medications and Oral Health		

Please note: Abnormal findings should be documented in the patient's record.

Fluoride varnish applied

Referral made to: Dental Specialist

Name of Dental Specialist

Including this visit, how many times has the child had a First Dental Home visit in your office? _____

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)