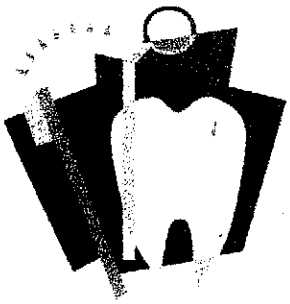
Dental Risk Assessment Questionnaire



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?	☐	☐
2. Does your child use a toothpaste with fluoride in it?	☐	☐
3. Do you help your child with toothbrushing?	☐	☐
4. Have you or your children ever had a bad dental experience?	☐	☐
5. Have any of your children ever had cavities?	☐	☐
6. Does your child complain of mouth pain?	☐	☐
7. Does your child take a bottle to bed?	☐	☐
8. Does your child walk around drinking from a bottle or cup?	☐	☐

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? ☐ Good ☐ Fair ☐ Poor

	Yes	No
12. Do you have any cavities?	☐	☐
13. Do your gums bleed?	☐	☐

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 _____

	Yes	No
HEALTH HISTORY		
Did the birth mother have any problems during pregnancy?	☐	☐
Was your child premature?	☐	☐
Was your child's birth weight low?	☐	☐
Were there any complications at birth?	☐	☐
Has your child been ill?	☐	☐
Is your child on any medications?	☐	☐
DIET AND NUTRITION		
Is/was your child breastfed?	☐	☐
Does your child sleep with a bottle?	☐	☐
Does your child drink from a cup?	☐	☐
Does your child walk around drinking from a bottle or cup?	☐	☐
Is your child on a special diet?	☐	☐
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?	☐	☐
Do you have well water?	☐	☐
Do you use bottled water?	☐	☐
Do you use a water conditioner or filtration system?	☐	☐
If yes, please list _____		
Do you use fluoride toothpaste for your child?	☐	☐
ORAL HABITS		
Does your child use a pacifier?	☐	☐
Does your child suck a thumb or fingers?	☐	☐
Does your child grind his/her teeth day or night?	☐	☐
INJURY PREVENTION		
Is your child walking?	☐	☐
Is your home childproofed?	☐	☐
Do you use a car seat for your child?	☐	☐
Has your child had an injury to his/her mouth or face?	☐	☐
ORAL DEVELOPMENT		
Does your child have any teeth?	☐	☐
Child's age (in months) when the first tooth came in? _____		
Has your child had teething problems?	☐	☐
Have you noticed any problems with your child's mouth or teeth?	☐	☐
Does your child complain of mouth pain?	☐	☐
Have any of your children ever had cavities?	☐	☐
Have you or your children ever had a bad dental experience?	☐	☐
ORAL HYGIENE		
Do you clean your child's gums/teeth?	☐	☐
Do you use a toothbrush to clean your child's teeth?	☐	☐
Do you use toothpaste to clean your child's teeth?	☐	☐

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