Risk Assessment Questionnaire

.....(Child-ages 1-13).....

Child's Name: _____ **Date:**_____

Dental Concerns (teeth, gums, crowding, thumb sucking/pacifier, eruption): _____

_____

Dental History:

Orthodontics: (braces, retainers, appliances) No☐ or Yes☐ N/A☐ if yes, Year: _____

Last cleaning (approx.): _____ Last x-rays: _____

Home Care Routine:

Brushing frequency: _____ Manual☐ Electric☐ Is a parent helping? No☐ or Yes☐

Flossing/Interproximal cleaning frequency: _____

Products (ex: manual floss, picks, etc.): _____

Other: (mouth wash, Waterpik, etc.) _____

Fluoride exposure (ex: toothpaste, rinses, Rx supplements/tabs, water): _____

Nutritional Information: Frequent Snacker? No☐ or Yes☐ if yes, what kind of snacks (ex: soda, milk, water, juice, crackers, carbs, fruits, veggies): _____

Family History:

If yes, list yourself or any family member(s)

Heart Disease/Condition: No☐ or Yes☐ _____

Diabetes: Type: 1 or 2 No☐ or Yes☐ _____

Cavities concerns (high risk):No☐ or Yes☐ _____

Periodontal/ Gum Disease: No☐ or Yes☐ _____

How is your child's immune system? (How many times a year do you get cold/flu): _____