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 tooth brushing?	☐	☐
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 walks around drinking from a bottle or cup?	☐	☐
9.	Do you have any cavities?	☐	☐
10.	Do your gums bleed?	☐	☐

11. How many times does your child eat a snack each day? _____
12. How many bottles does your child have each day? _____
13. How is your own dental health? ☐ Good ☐ Fa☐ Poor

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!

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 walks around drinking from a bottle or cup?	☐	☐
Is your child on a special diet?	☐	☐
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?	☐	☐
If 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 first tooth came in? _____		
Has your child had teething problems?	☐	☐
Have you noticed any problems with your child's mouth or teeth?	☐	☐
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?	☐	☐

PRIVACY NOTIFICATION: With a few exceptions, you have the right to request and be informed about the information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have 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)