

Risk Assessment

Child's name _____ **Date** _____

Child's age _____ **Child's next dental care visit** _____

Birth Date _____

HEALTH HISTORY

- Did birthmother have any problems during pregnancy?
- Was child premature?
- Was child's birthweight low?
- Were there any complications at birth?
- Has your infant been ill?
- Is your child on any medications?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Notes: _____

DIET AND NUTRITION

- Is/Was your child breastfed?
- Does your child sleep with a bottle?
- Does your child drink from a cup?
- Is your child on a special diet?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Notes: _____

FLUORIDE ADEQUACY

- Do you know the fluoride level of your water?
- Do you have well water?
- If yes, has the water been tested?
- Do you use bottled water?
- Do you use a water conditioner or filtration system?
- Does your child take fluoride supplements?
- If yes please list: _____
- Do you use a fluoridated toothpaste for your child?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Notes: _____

ORAL HABITS

- Does your child use a pacifier?
- Does your child suck a thumb or finger(s)?
- Does your child grind teeth day or night?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Notes: _____

INJURY PREVENTION/ TRAUMA

- Is your child walking?
- Is your home childproofed?
- Do you use a car seat for your child?
- Has your child had an oral/facial injury?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Notes: _____

ORAL DEVELOPMENT

- Does your child have any teeth?
- Child's age (in months) when first tooth erupted _____
- Has your child experienced teething problems?
- Have you noticed any oral problems in your child?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Notes: _____

ORAL HYGIENE

- Do you clean your child's teeth/gums?
- Do you use a toothbrush to clean your child's teeth?
- Do you use toothpaste to clean your child's teeth?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Notes: _____