



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.

Dental Risk Assessment & Oral Health Questionnaire

Parent/Guardian Name _____ Date _____
 Child Name _____ Child's Age _____

HEALTH HISTORY

CIRCLE ONE

Did the birth mother have any problems during pregnancy?	Yes	No
Was your child premature?	Yes	No
Was your child's birth weight low?	Yes	No
Were there any complications at birth?	Yes	No
Has your child been ill?	Yes	No
Is your child on any medications?	Yes	No

DIET AND NUTRITION

Is/was your child breastfed?	Yes	No
Does your child sleep with a bottle?	Yes	No
Does your child drink from a cup?	Yes	No
Does your child walk around drinking from a bottle or cup?	Yes	No
Is your child on a special diet?	Yes	No
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?	Yes	No
Do you have well water?	Yes	No
Do you use bottled water?	Yes	No
Do you use a water conditioner or filtration system?	Yes	No
If yes, please list _____		
Do you use fluoride toothpaste for your child?	Yes	No

ORAL HABITS

Does your child use a pacifier?	Yes	No
Does your child suck his/her thumb or fingers?	Yes	No
Does your child grind his/her teeth day or night?	Yes	No

INJURY PREVENTION

Is your child walking?	Yes	No
Is your home childproofed?	Yes	No
Do you use a car seat for your child?	Yes	No
Has your child had an injury to his/her mouth or face?	Yes	No

ORAL DEVELOPMENT

Does your child have any teeth?	Yes	No
Child's age (in months) when the first tooth came in _____		
Has your child had teething problems?	Yes	No
Have you noticed any problems with your child's mouth or teeth?	Yes	No
Does your child complain of mouth pain?	Yes	No
Have any of your children ever had cavities?	Yes	No
Have you or your children ever had a bad dental experience?	Yes	No

ORAL HYGIENE

Do you clean your child's gums/teeth?	Yes	No
Do you use a toothbrush to clean your child's teeth?	Yes	No
Do you use toothpaste to clean your child's teeth?	Yes	No

PARENT/GUARDIA

How is your own oral health?	Please circle:	Good / Fair / Poor
Do you have any cavities?	Yes	No
Do your gums bleed?	Yes	No

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)

