

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.

Child's Name _____ Birthdate _____ Age _____

Parent/ Guardian Name _____ Date _____

Please circle your answer.

- 1) Does your family drink water with fluoride in it or do your children take fluoride tablets? Yes No
- 2) Does your child use a toothpaste with fluoride in it? Yes No
- 3) Do you help your child with toothbrushing? Yes No
- 4) Have you or your children ever had a bad dental experience? Yes No
- 5) Have any of your children ever had cavities? Yes No
- 6) Does your child complain of mouth pain? Yes No
- 7) Does your child take a bottle to bed? Yes No
- 8) Does your child walk around drinking from a bottle or cup? Yes No
- 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
- 12) Do you have any cavities? Yes No
- 13) Do your gums bleed? Yes No

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!