

Dental History and Caries Risk Assessment

Patient Name: _____ Date: _____ Age: _____

Name of previous dentist _____ Dentist's phone # _____

- Have you had check up x-rays (4 bitewings) within the last year? Y N
- Have you had a full mouth series (about 18 x-rays) within the last 5 years? Y N
- Have you had deep cleanings or been told you have periodontal disease? If deep cleaning approximate date _____ Y N
- Do you have missing teeth and want to discuss replacement options? Y N
- Number of cavities in the past 3 years: None 1-2 3+
- *Has anyone in your immediate family had any cavities in the last 3 years? Y N
- *Do you frequently consume food or drinks high in sugars or acidic? Y N
- *Do you snack often between meals? (> 3 snack periods if under 12, > 1 snack if over 12) Y N
- *For young children, do they take a bottle or sippy cup with anything other than water to bed? Y N
- *Do you have dry mouth? Y N
- *Are you undergoing chemo or radiation therapy? Y N
- *Do you currently have braces? Y N
- Before today, have you been to a dental office for a check up and cleaning in the last 18 months? Y N
- Do you brush your teeth at least 2 times per day? Y N
- Do you use a fluoride toothpaste? Y N
- Do you floss every day? Y N
- Are your teeth sensitive to hot/cold/sweets? Y N
- Do you use tobacco? Y N
- Do you drink alcohol more than 3 days per week? Y N
- Do you have an eating disorder? Y N
- For children under 2, are/did they use a bottle or nurse past 14 months old? Y N
- Do you use a night or snore guard or a CPAP Y N

Do Not Write Below This Line

<input type="checkbox"/> Special health care needs (*If under 14)	Risk Factors	0	1-2	3+
<input type="checkbox"/> Exposed root surfaces				
<input type="checkbox"/> Many multi-surface restorations	None	L	H<6	H
<input type="checkbox"/> Enamel defects (spots, marbled, cracked, worn)			M6+	
<input type="checkbox"/> Misalignment				
<input type="checkbox"/> Restoration overhangs, open margins, clasps	Moderate	M	M	H
<input type="checkbox"/> Plaque				
<input type="checkbox"/> Other _____	High	H	H	H

Caries History in Past 3 Years

Treatment Recommendations: None Rx: Fluoride Toothpaste Fluoride Varnish every 6 months Fluoride Varnish every 3 months Chlorhexidine 1 wk/mo Other _____

