

**Patient Name** \_\_\_\_\_  
**Today's Date** \_\_\_\_\_

**Caries Risk Assessment**

1. Were there any unusual conditions during gestation (while mother pregnant)?

Yes or No.

If yes, please explain \_\_\_\_\_

2. Was the birth full term? Yes or No

If no, please explain, how many weeks? \_\_\_\_\_

3. Did child come home from hospital with mom? Yes or No

4. Did child take any medications during first year of life?

Yes or No

If yes, please explain \_\_\_\_\_

5. Has child had any surgeries or hospitalizations?

If yes, please explain \_\_\_\_\_

6. Has child had any previous cavities or restorations (fillings)? Yes or No

If yes, please explain as much as possible \_\_\_\_\_

7. Have any siblings or parents had cavities or restorations (fillings)?

Yes or No

If yes, please explain \_\_\_\_\_

8. Does your drinking water have fluoride in it? Yes No Don't Know

9. Does your child allow brushing and/or flossing? Yes or No

10. How would you describe your child's diet? \_\_\_\_\_

11. Do you believe your child is at risk for developing cavities? \_\_\_\_\_

If yes, why? \_\_\_\_\_

12. Does anyone in your family have a history of "soft teeth"? \_\_\_\_\_

Name of person completing this form \_\_\_\_\_

(Print your name)

Signature \_\_\_\_\_