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_____