Beech Lake Pediatric Dentistry
10855 Hwy 412 West, Lexington, TN 38351

# Cavity Risk Questionnaire:

Please answer each of the following questions concerning your child:

CHILD'S NAME: _____ DATE: _____

1. **What age** did your child get their first teeth?
   _____Before six months
   _____Between 6-12 months
   _____After 12 months of age

2. Have other family members **had cavities** within the past 3 years?
   _____No _____Yes _____Mom _____Dad
   Brother history of cavities?_____ Sister history of cavities?_____

3. Who **brushes** your child's teeth? _____Mom _____Dad _____Child _____No One
   How many times per day?_____ Or How many times per week? _____

4. Who **flosses** your child's teeth? _____Mom _____Dad _____Child _____No One
   How many times per day?_____ Or How many times per week? _____

5. Does your child **cooperate** for brushing/flossing?
   _____ Always _____ Sometimes _____Never

6. What **type of toothpaste** is used for your child? _____
   _____Non-fluoridated toothpaste
   _____Fluoride toothpaste
   _____Don't know
   _____None

7. **How much** toothpaste do you use? _____ pea size _____ larger
   Does your child swallow it? _____Yes _____No

8. Is your **water fluoridated?** ____Yes _____No _____Don't know

9. Do you use a **water filter?** _____Yes _____No

10. Does your child drink **bottled water?**
    _____Only bottled water _____ Yes Occasionally _____Never

11. Does your child take **fluoride drops or tablets**? _____Yes _____No
    If yes, at what age did he/she start taking them?_____
    Is he/she still taking them? _____Yes _____No

12. Has your child ever lived in a **fluoridated area**? _____Yes _____No _____ Don't know
    If yes, what age? _____ How long? _____

13. Does your child use a **fluoride mouthwash**? _____No _____Yes (Name of rinse _____)

14. Does your child take any medications frequently? If so, please list: _____

_____

15. Did/Does your child have any **oral habits**

_____Fingers _____Thumb _____Pacifier _____Grind his/her teeth ____Other

Stopped at age _____

16. When and **how often** does this habit occur?

____All the time ____Nap Time ____Tired Time

____Stress Time ____In bed at night ____Occasionally

17. Does your child **drink** from a ( circle) **BOTTLE** **SIPPY CUP** **REGULAR CUP**

18. **What liquid** does your child mostly drink?

____Water ____ Milk ____Juice ____Other

19. Does your child **eat between** meals?

_____No _____Occasionally _____Frequently

How many snacks between meals? _____

20. Does your child **drink between** meals?

_____No _____Occasionally _____Frequently

How many times does your child drink between meals? _____

21. Does your child regularly eat any of the following (circle all that apply)

**raisins** **fruit rollups** **fruit snacks** **candy in small pieces** **crackers** **suckers**

22. Is your child **breast fed**? ____ NO _____ Yes Currently _____At night in bed with mother

23. Does your child take **anything** other than a stuffed animal **to bed** with them at night?

_____Pacifier _____Blanket

24. Have you or your child's other parent had **braces**? _____Mom _____Dad _____Sibling

25. Has your child suffered **any injuries** to their mouth?

____No ____Yes What age?_____ Please Explain _____

_____

26. Do you have **any special concerns or comments?**

_____

_____

Parent / Guardian Signature _____