



## Cavity Risk Questionnaire

Please complete both sides of the following questions concerning your child.

CHILD'S NAME: \_\_\_\_\_

TODAY'S 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 with history of cavities
- Sister with 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**?  Yes  No

Name of rinse \_\_\_\_\_



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14. Does your child take any medications frequently?  Yes  No

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:  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 have

raisin's  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 \_\_\_\_\_