Dr. Stephanie A. Vondrak
Dr. Ashley A. Rainbolt

[PEDIATRIC RISK ASSESSMENT]

Child's name:_____ **Date:**_____
Child's Birthdate:_____ **Child's Pediatrician:**_____

Caregiver's last dental visit date:_____
Caregiver's Oral Health: □**Fair** □**Good** □**Poor**

Heath History:

Did mother have any problems during pregnancy?	□Yes	□No
Was child premature?	□Yes	□No
Was child's birthweight low?	□Yes	□No
Were there complications at birth?	□Yes	□No
Has your infant been ill/have disabilities?	□Yes	□No
Is your child on any medications?	□Yes	□No
If yes, please list_____		

Diet and Nutrition

Is/Was your child breast-fed?	□Yes	□No
Does your child sleep with a bottle?	□Yes	□No
Does your child drink from a cup?	□Yes	□No
Is your child on a special diet?	□Yes	□No
Does your child take any vitamins or supplements?	□Yes	□No
If yes, please list_____		

Oral Habits

Does your child use a pacifier?	□Yes	□No
Does your child suck a thumb or fingers?	□Yes	□No
Does your child grind teeth during day or night?	□Yes	□No
Does your child snore?	□Yes	□No

Injury Prevention/Trauma

Is your child walking?	□Yes	□No
Has your child had an oral/facial injury?	□Yes	□No

Oral Development

Child's age (in months) when first tooth erupted _____		
Has your child experienced teething problems?	□Yes	□No
Have you noticed oral problems in your child?	□Yes	□No

Oral Hygiene

Do you clean your child's teeth/gums?	□Yes	□No
Do you use a toothbrush to clean your child's teeth?	□Yes	□No
Do you use toothpaste to clean your child's teeth?	□Yes	□No
Do you use floss to clean your child's teeth?	□Yes	□No