



Oral Health Assessments7

Adult/Caregiver Screening

| | Low Risk | At Risk |
|---|--|--|
| 1. Where does the water that you use for cooking and drinking come from? <input type="checkbox"/> City water <input type="checkbox"/> Bottled water-type <input type="checkbox"/> Well water <input type="checkbox"/> Don't know | Yes | No |
| 2. Do you smoke, use chewing tobacco or snuff? | No | Yes |
| 3. What, and how often, do you eat? What do you eat and drink at meal time? <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Snacks <input type="checkbox"/> Many mini meals | Balanced diet with milk products | No regular meals |
| 4. Do you snack on sticky and/or sugary foods, drink soda pop or flavored sugar fruit drinks? | Never/ Occasionally | Often |
| 5. How do you take care of your teeth? <input type="checkbox"/> Brush <input type="checkbox"/> Floss How often? _____ | Yes | No |
| 6. Do you receive dental care? Who or where? _____ Last visit date: _____ | Yes | Emergency Only or Never |
| 7. Have you recently had: <input type="checkbox"/> Bad breath – Non-emergency <input type="checkbox"/> Bleeding gums – As soon as possible <input type="checkbox"/> Toothache – Emergency <input type="checkbox"/> Other dental concerns: _____ | No/Occasionally No No | See Dentist Yes/Chronic Yes Yes |
| Casual Observation: <ul style="list-style-type: none"> • Teeth discolored • Teeth have plaque or food particles • Missing Teeth • Visible decay/cavity • Swollen, red gums • Avoiding smiling or opening mouth | No No No No No No | See Dentist Yes Yes Yes Yes Yes |

Infant 0 – 11 Months Screening

| | Low Risk | At Risk |
|---|-------------------|---------------------|
| 1. Where does the water that you use for mixing your baby’s formula or food come from? <input type="checkbox"/> City water <input type="checkbox"/> Bottled water-type <input type="checkbox"/> Well water <input type="checkbox"/> Breast feeding <input type="checkbox"/> Don’t know Is your child taking fluoride drops? | Yes | No |
| | Yes | No |
| 2. Do you comfort your child between feedings with: <ul style="list-style-type: none"> • a pacifier dipped in sugary substance • bottle filled with milk, juice, or sugar flavored fruit drink | No | Yes |
| | No | Yes |
| 3. When feeding or comforting your child do you: <ul style="list-style-type: none"> • clean the pacifier in your mouth • share your spoon with child – testing food temperature • pre-chew your child’s food | No | Yes |
| | No | Yes |
| | No | Yes |
| 4. How do you, or your caregiver, clean your baby’s teeth or gums? Explain: | Cleans gums daily | Cleans occasionally |
| 5. Have you selected your child’s dentist? Who or where? Last visit date: Has your pediatrician examined your child’s mouth? | Yes | No |
| | Yes | No |
| 6. Do you know what to do if there are injuries to your child’s mouth and how to prevent them? | Yes | No |
| Lift the lip: <ul style="list-style-type: none"> • White/brown spots, or gray shading on teeth • Teeth with plaque • Decay/cavity • Not applicable | No | See Dentist |
| | No | Yes |
| | No | Yes |
| | No | Yes |
| | No | Yes |

SF/gjg REVISED 6/7/05

Early Childhood: 3 – 5 Years Screening

| | Low Risk | At Risk |
|--|---|----------------------------------|
| 1. Where does the water that you use for drinking and cooking come from? <input type="checkbox"/> City water <input type="checkbox"/> Bottled water-type <input type="checkbox"/> Well water <input type="checkbox"/> Don't know Is your child taking fluoride drops, tablets or vitamins with fluoride? | Yes Yes | No No |
| 2. When feeding or comforting your child do you: <input type="checkbox"/> clean the pacifier in your mouth <input type="checkbox"/> share your spoon with child <input type="checkbox"/> share cup or a straw with child | No No No | Yes Yes Yes |
| 3. What snacks and drinks do you feed your child? <input type="checkbox"/> Bottle <input type="checkbox"/> Cup | Non-sugary foods; juice & milk product at meals only | Any time |
| 4. How often does your child take any liquid or chewable medications (prescription and/or over the counter)? <input type="checkbox"/> Serious health problems <input type="checkbox"/> No serious health problems | Short duration | On-going |
| 5. When and how do you, or your caregiver, take care of your child's teeth? <input type="checkbox"/> Toothbrush <input type="checkbox"/> Supervised by an adult <input type="checkbox"/> Pea-size fluoridated toothpaste on brush | Cleans daily | Occasionally cleans |
| 6. Does your child receive dental care? Who or where? Last visit date: Has your pediatrician examined your child's mouth? | Yes Yes | No No |
| 7. Do you know what to do if there are injuries to your child's mouth and how to prevent them? | Yes | No |
| Lift the lip: <ul style="list-style-type: none"> • White/brown spots, or gray shading on teeth • Teeth with plaque • Decay/cavity | No No No | See Dentist Yes Yes Yes |

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School Age: 6 - 10 Years Screening

| | Low Risk | At Risk |
|---|--|------------------------|
| 1. Where does the water that you use for drinking and cooking come from? <input type="checkbox"/> City water <input type="checkbox"/> Bottled water-type <input type="checkbox"/> Well water <input type="checkbox"/> Don't know Is your child taking fluoride supplements? | Yes | No |
| 2. What, and how often, does your child eat? What does he/she eat and drink at meal time? <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Snacks <input type="checkbox"/> Many mini meals | Non-sugary foods; juice & milk products at meals only | Any time |
| 3. How often does your child take any liquid or chewable medications (prescription and/or over the counter)? <input type="checkbox"/> Serious health problems <input type="checkbox"/> No serious health problems | Short Duration | Ongoing |
| 4. When and how does your child take care of his or her teeth? <input type="checkbox"/> Toothbrush <input type="checkbox"/> Supervised by an adult <input type="checkbox"/> Pea-size fluoridated toothpaste on brush <input type="checkbox"/> Floss | Cleans Daily | Occasionally Cleans |
| 5. Does your child receive dental care? Who or where? Last visit date: Has your pediatrician examined your child's mouth? | Yes | No |
| 6. Does your child have <input type="checkbox"/> Bad breath? <input type="checkbox"/> Bleeding gums? <input type="checkbox"/> Toothache? | No | Yes |
| 7. Does your child have dental sealants on any of his/her teeth? | Yes | No |
| 8. Do you know what to do if there are injuries to your child's mouth and how to prevent them? | Yes | No |
| 9. Does your child use a mouthguard when playing sports? | Yes | No |
| Casual Observation: <ul style="list-style-type: none"> • Teeth discolored • Teeth have plaque or food particles • Missing teeth • Visible decay/cavity • Swollen, red gums • Avoid smiling or opening mouth | No | See Dentist Yes |

Adolescence: 11 – 21 Years Screening

| | Low Risk | At Risk |
|--|--|--|
| 1. Where does the water that you use for drinking and cooking come from? <input type="checkbox"/> City water <input type="checkbox"/> Bottled water-type <input type="checkbox"/> Well water <input type="checkbox"/> Don't know | Yes | No |
| 2. What and how often do you eat? <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Snacks | Non-sugary foods; juice & milk products at meals only | Any time |
| 3. Do you snack on sticky and/or sugary foods, drink soda pop or flavored sugar fruit drinks? | No | Yes |
| 4. How do you take care of your teeth? <input type="checkbox"/> Brush <input type="checkbox"/> Floss <input type="checkbox"/> Fluoridated toothpaste | Cleans Daily | Cleans Occasionally |
| 5. Do you receive dental care? Last visit date: Who or where? | Yes | No |
| 6. Do you have dental sealants on any of your teeth? | Yes | No |
| 7. Do you use a mouthguard when playing sports? | Yes | No |
| 8. Have you recently had: <input type="checkbox"/> Bad breath? <input type="checkbox"/> Bleeding gums? <input type="checkbox"/> Toothache? | No/Occasionally No No | See Dentist Yes/Chronic Yes Yes |
| 9. Do you smoke or use chewing tobacco or snuff? | No | Yes |
| 10. Do you have an oral piercing? | No | Yes |
| Casual Observation: <ul style="list-style-type: none"> • Teeth discolored • Teeth have plaque or food particles • Missing teeth • Visible decay/cavity • Swollen, red gums • Avoid smiling or opening mouth | No No No No No No | See Dentist Yes Yes Yes Yes Yes |