Dental History Form

Caries Risk Assessment American Dental Association

Patient Name:	
Date of Birth:	
Age:	

Contributing Conditions			
Do you use toothpaste or mouth rinses with fluoride content?	☐ Yes	☐ No	
How often do you consume sugary foods? (including juice, carbonated soft drinks, energy drinks, sugary coffee, medicinal syrups, honey, etc.)	☐ Primarily at mealtimes		☐ Between mealtimes
For patients ages 6-14 only: Has your parents, caregiver and/or other siblings had carious lesions (cavities) recently?	☐ No new carious lesions or restorations (dental fillings or crowns)	☐ 1 or 2 new carious lesions or restorations in the last 7-23 months	☐ New carious lesions or restorations in the last 6 months
General Health Conditions			
Do you have any special healthcare needs that prevents you from getting adequate oral healthcare, such as brushing and flossing everyday, by yourself your by your caregiver?	☐ No		☐ Yes
Are you currently going through any chemo/radiation therapy?	☐ No		☐ Yes
Do you have any eating disorders currently or in the past?	☐ No	☐ Yes	
Are you currently on any medications?	☐ No	☐ Yes	
Do you have a history of drug or alcohol abuse?	☐ No	☐ Yes	
Clinical Conditions			
Have you been told by a dental professional that you had a carious lesion (cavities)?	☐ No new carious lesions or restorations (dental fillings or crowns)	☐ 1 or 2 new carious lesions or restorations in the last 36 months	☐ 3 or more carious lesions or restorations in the last 36 months
By a Dental Professional Only			
Is this a patient of record?	☐ Yes	☐ No	
Teeth missing due to caries in past 36 months	☐ No		☐ Yes
Visible plaque	☐ No	☐ Yes	
Unusual Tooth Morphology that compromises Oral Hygiene	☐ No	☐ Yes	
Interproximal Restorations - 1 or more	☐ No	☐ Yes	
Exposed root surface	☐ No	☐ Yes	
Restorations with overhangs and/or open margins, open contacts with food impaction	☐ No		
Dental/Orthodontic appliances (fixed or removable)	☐ No		
Severe Dry Mouth	☐ No		