Infant Risk Assessment

Please Complete and Print Out

Child's Name: ""Date:

Child's Age: """"""""""""""""""""""""""""""Birth Date:

Health History

Question		
Did birthmother have any problems during pregnancy?	Yes	No
Was child premature?	Yes	No
Was child's birth weight low?	Yes	No
Were there any complications at birth?	Yes	No
Has your infant been ill?	Yes	No
Is your child on any medications?	Yes	No

Notes:

Diet and Nutrition

Question		
Is/was your child breastfed?	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

Notes:

Fluoride Adequacy

Question		
Do you know the fluoride level of your water?	Yes	No
Do you have well water?	Yes	No
If yes, has the water been tested?	Yes	No
Do you use bottled water?	Yes	No

Do you use a water conditioner or filtration system?	Yes	No
Does your child take fluoride suppliments?	Yes	No
If yes, please list:		
Do you use a fluoridated toothpaste for your child?	Yes	No
Notes:		

Oral Habits

Does your child use a pacifier?	Yes	No
Does your child suck a thumb or finger(s)?	Yes	No
Does your child grind teeth day or night?	Yes	No
Notes:		

Injury Prevention/Trauma

Is your child walking?	Yes	No
Is your home childproofed?	Yes	No
Do you use a car seat for your child?	Yes	No
Has your child had an oral/facial injury?	Yes	No
Notes:		

Oral Development

Does your child have any teeth?	Yes	No
Child's age (in months) when first tooth erupted:		
Has your child experienced teething problems?	Yes	No
Have you noticed any oral problems in your child?	Yes	No
Notes:		