Oral Health Pre-Visit Questionnaire

American Academy of Pediatrics EQIPP Helping You Improve Care for Children Available on PediaLink

For Parent/Guardian of Patients 11 Years and Under

Directions: Parent or Guardian of patient 11 years of age and under

1. Fill in Patient's Name
2. Fill in Patient's Age in years or months
3. Circle the correct answer in the boxes on the right, Yes, No, or Not Sure

Patient's Name: _____ Patient's Age: _____ (years or months)

1.	Do you have any questions or concerns about your child's teeth or mouth?	Yes	No	Not Sure
2.	Does your child have special health care needs that make it difficult for them or you to brush their teeth?	Yes	No	Not Sure
3.	Does your child have a dental home (a place where he or she can go for dental care)?	Yes	No	Not Sure
4.	Has your child had a dental visit in the past 6 months? If yes, Date: __/__/__/ Reason: _____ Provider: _____ Phone: _____	Yes	No	Not Sure
5.	Has your child ever had a cavity? If yes, has it been treated?	Yes Yes	No No	Not Sure Not Sure
6.	Have you (parent or caregiver) had a cavity in the past 12 months? If yes, has it been treated?	Yes Yes	No No	Not Sure
7.	**For infants and young children ≤3 years:** Does your child sleep with the bottle or breastfeed throughout the night? Does your child use a bottle or sippy cup most days of the week?	 Yes Yes	 No No	 Not Sure Not Sure
8.	Does your child frequently snack between meals most days of the week?	Yes	No	Not Sure
9.	Does your child drink sugary beverages or eat foods that stick to their teeth, such as sticky candy, most days of the week?	Yes	No	Not Sure
10.	Does your child drink fluoridated water or take fluoride supplements most days of the week?	Yes	No	Not Sure
11.	On most days, how often are your child's teeth brushed each day? For infants, are gums wiped after feeding?	2 times	1 time	0
12.	Does your family use fluoride toothpaste?	Yes	No	Not Sure
13.	Has your child had a fluoride varnish treatment in the past 6 months? If Yes, where was the varnish applied? ☐ Doctor's office ☐ Dentist office ☐ School	Yes	No	Not Sure
14.	What is one thing you can think of to do better to keep your child's mouth healthy?			

Copyright © 2021 American Academy of Pediatrics.
All rights reserved.

Oral Health Pre-Visit Questionnaire

American Academy of Pediatrics EQIPP Helping You Improve Care for Children Available on PediaLink

For Patients (12-21 Years)

Patient's Name: _____ Patient's Age: _____ years

Any question with a response in a **shaded box** indicates a potential risk factor.				
1.	Do you have any questions or concerns about your teeth or mouth?	Yes	No	Not Sure
2.	Do you have special health care needs?	Yes	No	Not Sure
3.	Do you have a dental home (a place where you can go for dental care)?	Yes	No	Not Sure
4.	Have you had a dental visit in the past 6 months? If yes, Date: __/__/__/ Reason: _____ Provider: _____ Phone: _____	Yes	No	Not Sure
5.	Have you had a cavity or swollen painful gums in the past 12 months? If yes, has it been treated? Details: _____	Yes Yes	No No	Not Sure Not Sure
6.	Do you drink fluoridated water, such as tap water with fluoride, most days of the week?	Yes	No	Not Sure
7.	On average, how many times do you brush your teeth each day?	2 times	1 time	0
8.	Do you brush your teeth using fluoride toothpaste?	Yes	No	Not Sure
9.	Do you use a mouth rinse that contains fluoride?	Yes	No	Not Sure
10.	Do you frequently snack between meals most days of the week?	Yes	No	Not Sure
11.	Do you drink sugary drinks (including soda pop, sports drinks, juice, energy drinks, etc) most days of the week?	Yes	No	Not Sure
12.	Do you eat foods that stick to your teeth, such as sticky candy, most days of the week?	Yes	No	Not Sure
13.	Do you wear braces or another dental appliance? If so, describe: _____	Yes	No	Not Sure
14.	Do you have tongue, cheek or lip piercings or are you planning on any?	Yes	No	Not Sure
15.	Do you smoke or chew tobacco, use e–cigarettes or use any other recreational drugs? If so, describe: _____	Yes	No	Not Sure
16.	What is one thing you can think of to do better to keep your mouth healthy?			

FOR OFFICE USE ONLY: Any question with a response in a **shaded box** indicates a potential risk factor.

Copyright © 2021 American Academy of Pediatrics.
All rights reserved.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™