Directions

This PreVisit Questionnaire is a tool that can be used to screen a patient's risk for oral diseases. It can assist you in efficiently assessing your patient's risk for cavities, periodontal disease, mouth injuries, and more and help you determine where intervention and anticipatory guidance are needed.

The Oral Health PreVisit Questionnaire can be completed by the parent while they are in the waiting room or at the start of the visit. For families with adolescents, have the adolescent also fill out the adolescent version. See below.

+ PreVisit Parent Questionnaire (for all patients)
+ PreVisit Adolescent Questionnaire (for children over 12 years of age)

You may notice that certain areas in the questionnaires are shaded. Any question with a response in a shaded box indicates a risk factor that may require counseling, anticipatory guidance, or other actions. For guidance on how to provide counseling or anticipatory guidance try using the Bright Futures Oral Health Pocket Guide or the AAP Bright Futures Oral Health Risk Assessment Tool and Guidance.

Treatment for children at high risk for caries (as determined from answers on the PreVisit Questionnaire and an oral health risk assessment performed by the care team) may include the following:

1. Professionally applied fluoride varnish
2. Anticipatory guidance regarding minimizing caries risk factors and promoting optimal oral health
3. A referral to a pediatric dentist or a dentist comfortable caring for children
4. Follow-up to ensure that caries risk factors are being minimized

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

Please take a few minutes to answer some questions regarding your child's oral health.

1.	Does your child have any oral health issues?	Yes	No
2.	Do you have any questions or concerns about your child's teeth or mouth?	Yes	No
3.	Does your child have special health care needs?	Yes	No
4.	Does your child have a dental home (a place where he or she can go for any dental care)?	Yes	No
5.	Has your child had a dental visit in the past 6 months? If yes, please specify the date of last dental visit: _____ What is the name of your dentist: _____	Yes	No
6.	Has your child ever had a cavity? If yes, has it been treated?	Yes Yes	No No
7.	Have you (mother or primary caregiver) had a cavity in the past 12 months?	Yes	No
8.	Does your child eat snacks most days of the week?	Yes	No
9.	Does your child eat foods that stick to their teeth such as sticky candy, raisins, etc., most days of the week?	Yes	No
10.	Does your child drink fluoridated water or take fluoride supplements most days of the week?	Yes	No
11.	Do you brush your child's teeth twice daily with toothpaste that has fluoride?	Yes	No
12.	Has your child had a fluoride varnish treatment in the past 6 months?	Yes	No
13.	Does your child wear a mouth guard when playing in sports or other activities?	Yes	No
14.	Do you floss your child's teeth if there are at least two teeth touching?	Yes	No
For family with children less than 3 years of age:			
15.	Does your child sleep with a bottle?	Yes	No
16.	Does your child breastfeed throughout the night?	Yes	No
17.	Does your child use a bottle or sippy cup containing drinks other than water most days of the week?	Yes	No

Name: _____ Age: _____

Please take a few minutes to answer some questions regarding your oral health.

1.	Do you have any oral health issues?	Yes	No
2.	Do you have any questions or concerns about your teeth or mouth?	Yes	No
3.	Do you have special health care needs?	Yes	No
4.	Do you have a dental home (a place where you can go for dental care)?	Yes	No
5.	Have you had a dental visit in the past 6 months? If yes, please specify the date of last dental visit: _____ What is the name of your dentist: _____	Yes	No
6.	Have you had a cavity or swollen painful gums in the past 12 months? If so, has it been treated?	Yes Yes	No No
7.	Do you drink fluoridated water, such as fluoride tap water, most days of the week?	Yes	No
8.	Do you brush your teeth at least twice daily with toothpaste that has fluoride?	Yes	No
9.	Do you use a mouth rinse that contains fluoride most days of the week?	Yes	No
10.	Have you had a fluoride varnish treatment in the past 6 months?	Yes	No
11.	Do you eat snacks most days of the week?	Yes	No
12.	Do you drink sugary drinks (including soda pop, flavored water, sports drinks, juice, energy drinks, etc.) most days of the week?	Yes	No
13.	Do you eat foods that stick to the teeth such as sticky candy, raisins, etc., most days of the week?	Yes	No
14.	Do you floss your teeth daily?	Yes	No
15.	Do you have tongue or lip piercing or are you planning on having this done?	Yes	No
16.	Do you wear braces?	Yes	No
17.	Do you smoke cigarettes, chew tobacco, or use any other recreational drugs? Describe:_____	Yes	No
18.	Do you wear a mouth guard when playing in sports or other activities?	Yes	No