PREVENTATIVE, RESTORATIVE & COSMETIC DENTIST
DR.Q | CHARLYN QUIEC, DMD
139 E Colorado Blvd #1, Monrovia, CA 91016 | (626) 599.9818 | drqdental.net

ADA American Dental Association®

CARIES RISK ASSESSMENT FORM (AGE >6)

Patient Name:		Birth Date:
Age:	Date:	Initials:

		Low Risk	Moderate Risk	High Risk
	Contributing Conditions	Check the conditions that apply		
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	Yes ☐	No ☐	
II.	**Sugary Foods or Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at Mealtimes ☐		Frequent or prolonged between meal exposures/day ☐
III.	**Caries Experience of Mother, Caregiver and/or other Siblings** (for patients ages 6-14)	No carious lesions in last 24 months ☐	Carious lesions in last 7-23 months ☐	Carious lesions in last 6 months ☐
IV.	**Dental Home:** Established patient of record, receiving regular dental care in a dental office.	Yes ☐	No ☐	
	General Health Conditions	Check the conditions that apply		
I.	**Special Healthcare Needs** (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral healthcare by themselves or caregivers)	No ☐	Yes (over age 14) ☐	Yes (ages 6-14) ☐
II.	Chemo/Radiation Therapy	No ☐	Yes ☐	Yes ☐
III.	Eating Disorders	No ☐	Yes ☐	
IV.	Medications that Reduce Salivary Flow	No ☐	Yes ☐	
	Clinical Conditions (For Dr. Q's Use Only)	Check the conditions that apply		
I.	**Cavitated or Non-Cavitated** (incipient) **Carious Lesions or Restorations** (visually or radiographically evident)	No new carious lesions or restorations in last 36 months ☐	1 or 2 new carious lesions or restorations in last 36 months ☐	3 or more carious lesions or restorations in 36 months ☐
II.	Teeth Missing Due to Caries in past 36 months	No ☐	Yes ☐	Yes ☐
III.	Visible Plaque	No ☐	Yes ☐	
IV.	**Unusual Tooth Morphology** that compromised oral hygiene	No ☐	Yes ☐	
V.	Interproximal Restorations- 1 or more	No ☐	Yes ☐	
VI.	**Exposed Root Surfaces** present	No ☐	Yes ☐	
VII.	**Restorations with Overhangs** and/or **Open Margins; Open Contacts** with food impaction	No ☐	Yes ☐	
VIII.	**Dental/Orthodontic Appliances** (fixed or removable)	No ☐	Yes ☐	
IX.	Severe Dry Mouth (Xerostomia)	No ☐	Yes ☐	Yes ☐

Overall assessment of dental caries risk: ☐ Low ☐ Moderate ☐ High

Patient Instructions:

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Total Health™ BEYOND THE MOUTH

TOTAL HEALTH CHECKLIST

PATIENT:

This information will assist the dental professionals in assessing your oral health and its impact on your overall health. Please answer completely to the best of your knowledge.

Patient Name (Last Name, First Name): _____

Height: _____ Weight: _____

How frequently have you been brushing your teeth? _____

How frequently have you been flossing your teeth? _____

Do your gums bleed? ..... Yes ___ No ___

Are your gums sore or swollen? ..... Yes ___ No ___

Have your gums receded (do teeth look longer)? ..... Yes ___ No ___

Are your teeth loose? ..... Yes ___ No ___

Do you smoke or use tobacco products? ..... Yes ___ No ___

Do you drink excessively? ..... Yes ___ No ___

Do you have a persistent sore throat or ear pain? ..... Yes ___ No ___

Do you have unexplained numbness or pain in the face/neck/mouth? ..... Yes ___ No ___

Do you have a sore or lesion on the lips or mouth that has persisted for 2 weeks or more? ..... Yes ___ No ___

Do you have chronic hoarseness? ..... Yes ___ No ___

Do you have difficulty chewing, swallowing, or moving the jaw or tongue? ..... Yes ___ No ___

Do you have a lump or thickening in the cheek? ..... Yes ___ No ___

Do you snore or have you been told in the past you snore? ..... Yes ___ No ___

Do you regularly have excessive daytime sleepiness? ..... Yes ___ No ___

Have you been diagnosed with sleep apnea? ..... Yes ___ No ___

Do you have a heart condition? ..... Yes ___ No ___

Is there a history of heart disease in your immediate family? ..... Yes ___ No ___

Do you have a family history of diabetes? ..... Yes ___ No ___

Do you have high cholesterol? ..... Yes ___ No ___

Do you have any other health conditions? ..... Yes ___ No ___

FOR OFFICE USE ONLY

Record Blood Pressure:

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SMILE EVALUATION

PATIENT:

Hold a full face mirror 12" - 14" from your face. Smile to show your teeth; take time to observe your teeth carefully. Then answer the following questions.

1 Do you like the appearance of your teeth, your smile? YES ☐ NO ☐

If not, explain _____

2 Are your teeth all in alignment (straight)? YES ☐ NO ☐

If not, explain _____

3 Do you have spaces that you don't like? YES ☐ NO ☐

If yes, explain _____

4 Do you like the color of your teeth? YES ☐ NO ☐

If not, explain _____

5 Do you like the shape of your teeth? YES ☐ NO ☐

If not, explain _____

6 Are your teeth...? Chipped ☐ Protruding ☐ Hidden ☐

7 Do you like how your teeth come together? YES ☐ NO ☐

If not, explain _____

8 Are there old fillings or dental work that you don't like looking at? YES ☐ NO ☐

If yes, explain _____

9 What would you like to change the most in the appearance of your teeth? _____

_____

10 How would you like your teeth to look? _____

_____