RoMoNOH Parent/Caregiver Oral Health Risk Assessment

Child's Name: _____

Child's Date of Birth:_____

Today's Date: _____

To be completed by parent or caregiver at every well child visit (ages 6 months to 6 years).

These questions help us assess your child's risk for cavities. Circle your answer.

1.	Has your child ever had a cavity?	Yes	No	Not sure
2.	In the past year, have you (parent or caregiver) had a cavity?	Yes	No	Not sure
3.	Does your child sleep with a bottle containing milk, formula, juice, or anything other than water?	Yes	No	Not sure
4.	On most days, does your child drink from a bottle or non-spill (sippy) cup other than plain water (nothing added)?	Yes	No	Not sure
5.	On most days, does your child have three or more sugary snacks such as crackers, candy, or sugary drinks or juice?	Yes	No	Not sure
6.	On most days, how many times are your child's teeth brushed each day?	1	2 or more	0
7.	When your child's teeth are brushed, is fluoride toothpaste usually used?	Yes	No	Not sure
8.	Does your child drink tap water with fluoride every day?	Yes	No	Not sure
9.	Has your child seen a dental provider in the 6 months and received fluoride?	Yes	No	Not sure
10.	Does your child have any special healthcare that makes it hard for you to brush their teeth?	Yes	No	Not sure
11.	What is one thing you think you could do better to keep your child's teeth healthy? _____ _____			

Instructions: Any shaded response = caries risk is high. Recommend fluoride varnish application if not child has not received in the previous 3 months and oral health anticipatory guidance, a dental referral, and caregiver goal setting.

Publication date: 2022

The Rocky Mountain Network of Oral Health is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, or endorsement by, HRSA, HHS, or the U.S. government. For more information, please visit www.HRSA.gov.

RoMoNOH Parent/Caregiver Oral Health Risk Assessment

El nombre del niño/a:_____

Fecha de nacimiento del niño/a:_____

La Fecha de Hoy: _____

To be completed by parent or caregiver at every well child visit (ages 6 months to 6 years)

Estas preguntas nos ayudan a evaluar el riesgo de caries de su hijo/a. Encierra en un círculo tu respuesta.

1.	¿Alguna vez su hijo/a tuvo una caries?	Si	No	No segura
2.	En el último año, ¿tuvo usted (padre o cuidador) una caries?	Si	No	No segura
3.	¿Duerme su hijo con un biberón que contiene leche, fórmula, jugo o cualquier otra cosa que no sea agua?	Si	No	No segura
4.	En la mayoría de los días, ¿bebe su hijo de un biberón o una taza de bebido que no se derrame (sippy) que no sea agua corriente (sin agregar nada)?	Si	No	No segura
5.	En la mayoría de los días, ¿tiene su hijo tres o más refrigerios azucarados como galletas, dulces o bebidas o jugos azucarados?	Si	No	No segura
	En la mayoría de los días, ¿cuántas veces se cepillan los dientes de su hijo cada día?	1	2 or mas	0
6.	Cuando se cepillan los dientes de su hijo, ¿se usa generalmente pasta dental con fluoruro?	Si	No	No segura
7.	¿Bebe su hijo agua corriente con fluoruro todos los días?	Si	No	No segura
8.	¿Ha visto su hijo un proveedor dental en los 6 meses y recibió fluoruro?	Si	No	No segura
9.	¿Tiene su hijo alguna necesidad especial de atención médica que limite su capacidad de cepillarse los dientes?	Si	No	No segura
10.	¿Qué cosa cree que podría hacer mejor para mantener sanos los dientes de su hijo/a? _____ _____			

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