HARBOR COUNTRY DENTAL
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PreVisit Caries Risk Assessment
Adolescent Questionnaire

Patient's 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 ever had a cavity or swollen painful gums in the past 12 months? If so, has it been treated?	Yes	No
7.	Do you drink fluoridated water, such as 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 drink sugary drinks (including soda pop, flavored water, sports drinks, juice, energy drinks, etc.) most days of the week?	Yes	No
12.	Do you eat foods that stick to the teeth such as sticky candy, raisins, etc., most days of the week?	Yes	No
13.	Do you floss your teeth daily?	Yes	No
14.	Do you have tongue or lip piercings or are you planning on having this done?	Yes	No
15.	Do you wear braces?	Yes	No
16.	Do you smoke cigarettes, chew tobacco, or use any other recreational drugs? Describe:_____	Yes	No
17.	Do you wear a mouth guard when playing sports or other activities?	Yes	No