

EARLY CHILDHOOD DENTAL HEALTH QUESTIONNAIRE

(CRA)

Prenatal, Natal, Neonatal History

- | | | |
|--|----|-----|
| 1. High Risk Pregnancy | NO | YES |
| 2. Tetracycline Ingestion During Pregnancy | NO | YES |
| 3. Pre-Term or Low Birth Weight | NO | YES |

Comments: _____

Developmental History

1. Age First Tooth Erupted: _____ months

Comments: _____



Medical History

- | | <u>Low Risk</u> | <u>Moderate Risk</u> | <u>High Risk</u> |
|---|-----------------|----------------------|------------------|
| 1. Number of Otitis Media (<i>Ear Infection</i>) Episodes | 0-1 | 2-3 | more than 3 |
| 2. Frequency of Antibiotics Prescribed | None | Low | High |
| 3. Multiple Fevers Early in Life | No | | Yes |

Other Childhood Illnesses _____

Family History

- | | | | |
|--------------------------------|-----|----------|------|
| 1. Parent's Frequency of Decay | Low | Moderate | High |
| 2. Siblings Frequency of Decay | Low | Moderate | High |

Child's Dental History

- Previous Dental Trauma _____
- Bruxism (*Grinding or Clenching*) _____
- Teething Difficulties _____



Oral Habits

- | | | |
|--|---|----|
| 1. Sucks Pacifier | YES | NO |
| -Does care-giver clean pacifier by sticking it in their mouth? | YES | NO |
| -Does it get dipped in a sugary substance? | YES | NO |
| **If so, explain _____ | | |
| 2. Sucks Thumb (<i>Complete answers below</i>) | YES | NO |
| 3. Sucks Fingers (<i>Complete answers below</i>) | YES | NO |
| -How often? | ___ Only at night ___ When sleepy ___ When bored ___ When nervous | |

Home Care (*Circle response*)

- | | | | | |
|-----------------------------------|--------------|---------------------|-------------------------|------------------------------|
| 1. Are teeth being cleaned? | No | Washcloth | Toothbrush | |
| 2. Who is brushing? | Parent | Child | Parent and child | |
| 3. When are teeth being brushed? | Only morning | Only night | Morning and Night | After feedings |
| 4. What toothpaste is being used? | None | Fluoride Toothpaste | Non-Fluoride Toothpaste | Training paste w/no Fluoride |



Water and Fluoride Sources

- Where does water used for drinking and cooking come from?
 City Water Well Water Bottled Water Purified or Filtered Water
- Does drinking water have fluoride in it?
 Yes No Don't Know
- Is child currently taking fluoride drops, tablets, or vitamins with fluoride in them? Yes No
- Does child spend time anywhere other than home?
 Daycare Babysitter Other Care Giver
- Does that place have fluoride in the water?
 Yes No Don't Know



OFFICE USE ONLY

SUPPLEMENTAL FLUORIDE TABLE
Concentration of Fluoride in Water

Age	<0.3 ppm F	0.3-0.6 ppm F	>0.6 ppm F
Birth to 6 months	0*	0	0
6 months to 3 years	0.25	0	0
3 years to 6 years	0.5	0.25	0
6 years to 16 years	0	0.5	0



Feeding History

- Did/does the child breastfeed? Yes No Until what age? _____
- | | <u>Low Risk</u> | <u>Moderate Risk</u> | <u>High Risk</u> |
|-------------------------------------|-------------------|----------------------|---|
| A. How many times (circle response) | 1-3x a day | 4-6x a day | Over 6x a day |
| B. Duration of feeding | < than 15 minutes | 15-30 minutes | > 30 minutes
Feeding on demand
Feeding over night in parent's bed |
- Did/does the child drink from a bottle? Yes No Until what age? _____
- | | | | |
|---|-----------------------------|----------------------|------------------------------|
| A. What's in the bottle? <input type="checkbox"/> Milk <input type="checkbox"/> Juice <input type="checkbox"/> Water Other _____ | | | |
| | <u>Low Risk</u> | <u>Moderate Risk</u> | <u>High Risk</u> |
| B. How many times (circle response) | 1-3x a day | 4-6x a day | Over 6x a day |
| C. Duration of feeding | < 15 minutes | 15-30 minutes | > 30 minutes |
| D. Bottle given while lying down | <input type="checkbox"/> No | | <input type="checkbox"/> Yes |
| E. Bottle given as pacifier | <input type="checkbox"/> No | | <input type="checkbox"/> Yes |

OFFICE USE ONLY

Oral Examination (Lift the Lip)

- Plaque present on teeth No Yes
 - White/brown spots or stains on teeth No Yes
 - Decay/cavity No Yes
 - Has child ever been to a dentist? No Yes
- Dentist's Name _____ Date of last visit ____/____/____

