Caries Risk Assessment

PATIENT INFORMATION

Name: _____ Age: _____

Gender: _____ Date of Assessment: _____ dd / mm / yyyy

Dental History

Medical History

ASSESSMENT FACTORS

1. Past Dental History

Number of cavities in the past year: _____ Number of restorations: _____

Presence of previous orthodontic treatment

◯ Yes ◯ No

2. Medical History

Presence of chronic medical conditions

◯ Yes ◯ No

Medications that may affect oral health:

Xerostomia (dry mouth)

◯ Yes ◯ No

3. Oral Hygiene Habits

Frequency of brushing: _____ Type of toothbrush: _____

Use of fluoride toothpaste

◯ Yes ◯ No

Frequency of flossing: _____

4. Diet and Nutrition

Frequency of sugary food and beverage consumption:

Snacking habits between meals: _____

5. Salivary Factors

Presence of reduced salivary flow

◯ Yes ◯ No

pH of saliva: _____

6. Socioeconomic Factors

Access to dental care: _____ Socioeconomic status: _____

7. Bacterial Factors

Presence of Streptococcus mutans or Lactobacillus

◯ Yes ◯ No

Use of antibacterial mouthwash

◯ Yes ◯ No

8. Fluoride Exposure

Fluoridated water source

◯ Yes ◯ No

Use of fluoride supplements

◯ Yes ◯ No

Professional fluoride treatments

◯ Yes ◯ No

9. Radiographic Findings

Presence of interproximal caries

◯ Yes ◯ No

Presence of occlusal caries

◯ Yes ◯ No

10. Additional Comments

CARIES RISK ASSESSMENT:

Risk Level

◯ Low Risk ◯ Moderate Risk ◯ High Risk

RECOMMENDATIONS:

Dental treatment required

Oral hygiene instructions

Diet and nutritional counseling

Fluoride recommendations

Recall interval: _____

Provider's Signature

Date: _____ dd / mm / yyyy