

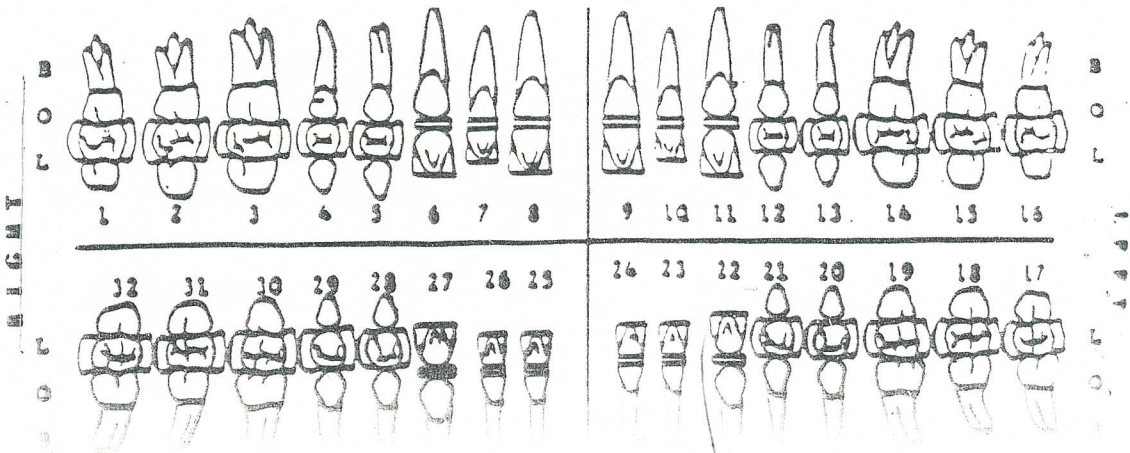
DEPARTMENT OF RESTORATIVE SERVICES CARIES DIAGNOSIS AND PREVENTION WORKSHEET

I. Caries Risk Assessment Questionnaire (To be completed by patient.)

Please X the box in front of any of the following statements that apply to you. This will help us determine your individual need for a specific therapeutic program that can help you keep your teeth for life.:

- No fluoride in drinking water as a child
- No fluoride in your drinking water now
- Drink filtered or bottled water
- Use fluoridated products currently
- Have multiple fillings and/or crowns
- Strong family history of dental decay
- Have sensitivity to hot, cold, or touch
- Visit dental office irregularly
- Brush less than 2 times per day
- Floss less than once per day
- Limited hand dexterity
- Use home whitening products
- Use of chewing gum, lozenges, or hard candy with sugar between meals; or strong breath mints
- Mouth feels dry; or take medications that cause dry mouth; or breathe through mouth
- Currently undergoing (or history of) chemotherapy or radiation therapy
- Suffer from acid reflux
- Currently wear orthodontic braces
- Teeth that just don't feel clean or trap food
- Dental work done in the past year
- Have receding gums or history of gum disease
- Snack frequently between meals
- Sip on beverages throughout day (other than water)
- Use tobacco products of any type
- Grind teeth frequently

II. EXISTING DISEASE AND RESTORATIONS. (Use data collected from clinical exam and radiographs to complete this charting.)



III. ASSESSMENT OF CARIES RISK FACTORS

Analyze the data that you have gathered from sections I and II. Use the following Table to guide you in assessing the caries risk for your patient. Check all that apply to your patient, then assign your patient a caries risk level.

<u>Low Risk</u>	<u>Moderate Risk</u>	<u>High Risk</u>
<input type="checkbox"/> No carious lesions in last 3 years	<input type="checkbox"/> One carious lesions in last three years	<input type="checkbox"/> Two or more carious lesions in last 3 years
<input type="checkbox"/> Adequately restored surfaces, smooth margins	<input type="checkbox"/> Aging restorations, poor margin integrity	<input type="checkbox"/> Old restorations, poor marginal integrity
<input type="checkbox"/> Good Oral hygiene	<input type="checkbox"/> Fair oral hygiene habits	<input type="checkbox"/> Poor oral hygiene
<input type="checkbox"/> Regular dental visits	<input type="checkbox"/> Exposed root surfaces	<input type="checkbox"/> Past root caries or large #'s of exposed root surfaces
<input type="checkbox"/> Optimal fluoride content in primary drinking water source	<input type="checkbox"/> White spot lesions or interproximal radiolucencies	<input type="checkbox"/> Unsealed deep pits and fissures
	<input type="checkbox"/> Irregular dental visits	<input type="checkbox"/> Frequent sugar intake and eating "events"
	<input type="checkbox"/> Orthodontic patient	<input type="checkbox"/> Inadequate salivary flow
	<input type="checkbox"/> Impaired ability to maintain oral hygiene	<input type="checkbox"/> Family of low socioeconomic status or lack of dental insurance
	<input type="checkbox"/> Sub-optimal fluoride content of primary drinking water source	<input type="checkbox"/> Elevated mutans streptococci count
		<input type="checkbox"/> Impaired ability to maintain oral hygiene
		<input type="checkbox"/> Orthodontic patient
		<input type="checkbox"/> Irregular dental visits
		<input type="checkbox"/> Sub-optimal fluoride content of primary drinking water source

Results of Caries Risk Assessment (circle one): **Low Risk** **Moderate Risk** **High Risk**

If caries risk is low, reinforce oral hygiene habits and continue with appropriate treatment sequence developed in the treatment plan. In-office therapeutics (fluoride application) may be applied post-periodontal therapy, as necessary.

IV. DIET:

Complete a diet survey and prescribe 7 day recall diet diary. The analysis of this dietary data will lead to specific desirable dietary changes to be entered in the daily treatment log, in the patient record, and reinforced through patient counseling.

Date of Initial Survey and issue of 7 Day Recall Diary : _____

Recommendations: _____

Date of Recall and Revaluation of Patient Progress: _____

Recommendations: _____