



Pt. Name:

Date:

<u>DENTAL DECAY RISK ASSESSMENT</u>	YES	NO
Yes responses may indicate increased susceptibility to decay.		
1. Do you have decay currently		
2. Have you had any fillings placed in the last 3 years		
3. Has your dentist indicated that there are areas that he or she needs to watch because they are somewhat suspicious on x-ray		
4. Are you overdue for a dental check up?		
MEDICAL CONDITIONS		
5. Are you taking medications that decrease your saliva?		
6. Are you or have you undergone radiation therapy for cancer treatment?		
7. Are you or have you undergone chemo. for cancer treatment?		
8. Are you currently in a hormonal change (teenager, pregnant mother, menopause)?		
SELF INDUCED RISK FACTORS		
9. Are you a soda pop drinker?		
10. Are you a sports drink user?		
11. Are you an athlete?		
12. Are you a smoker?		
13. Are you a hard candy, cough drops and mint user?		
PROTECTIVE FACTORS (these will increase your score)		
14. Drink fluoridated tap water not bottled water?		
15. Use fluoride toothpaste?		
16. Use extra fluoride as in a fluoride treatment at your dentist appt.?		
17. Use sugar free gum?		
18. Use oral products with xylitol?		