Prenatal Dental Visit Checklist

	Yes	No	Comment
Name:			
DOB:			
MR#:			
Date:			
Blood Pressure: _____ / _____ If BP ≥ 140/90, contact OB doctor ASAP			
Maternity Due date:			
Updated Medical History			
Medications:			
Social status:			
Smoking			
Alcohol use			
Recreational drug use			
Oral Health History:			
Acute vs. non acute dental issues			
Periodontal issues:			
pregnancy gingivitis			
periodontitis exacerbation			
Dental erosion due to vomiting or gastric reflux			
Caries risk assessment:			
Oral conditions:			
Dental caries:			
Pyogenic granuloma			
Tooth mobility			
X-rays taken			
Home dental care practices:			
Brushing 2x/day			
Flossing			
Discuss treatment options with the patient; explain the safety of all procedures and medications during pregnancy.			
Recommend professional dental care for child by age of one			
Follow up appointment:			