

Young Children Dental Exam Checklist

	Yes	No	Comment
Name 姓名:			
DOB 生日:			
MR# 病歷號碼:			
Date 日期:			
Reviewed Medical History 回顧病史			
Medication 服用藥物:			
PCP Name 主治醫師姓名:			
Social History 家庭背景:			
Exposure to second-hand smoking 家人是否有人吸煙			
Siblings with caries 兄弟姐妹有沒有蛀牙			
Childcare provider caries status 父母親有沒有蛀牙			
Oral Health History 口腔健康病史:			
Habits--digits sucking 有沒有吸吮手指			
Pacifier use beyond one year of age 超過一歲有沒有用奶嘴			
Bruxism 睡覺有沒有磨牙			
Use and frequency of sugary food and drinks 有沒有經常吃甜的食物和飲料			
Night time feeding 有沒有夜晚餵奶			
Dental 牙齒:			
Any acute dental issues			
Caries risk assessment			
Fluoride exposure: resides in a fluoridated community			
Assess eruption sequence, growth and development			
Perform Knee-Knee examination			
Discuss oral hygiene instructions			
Fluoride varnish application			
Follow up appointment			