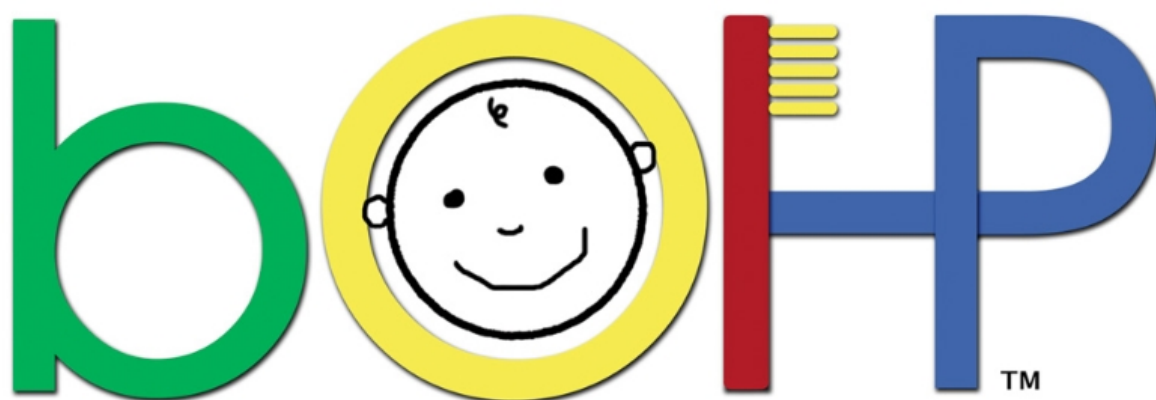


bOHP Newsletter July 2015 (10)

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## BABY ORAL HEALTH PROGRAM

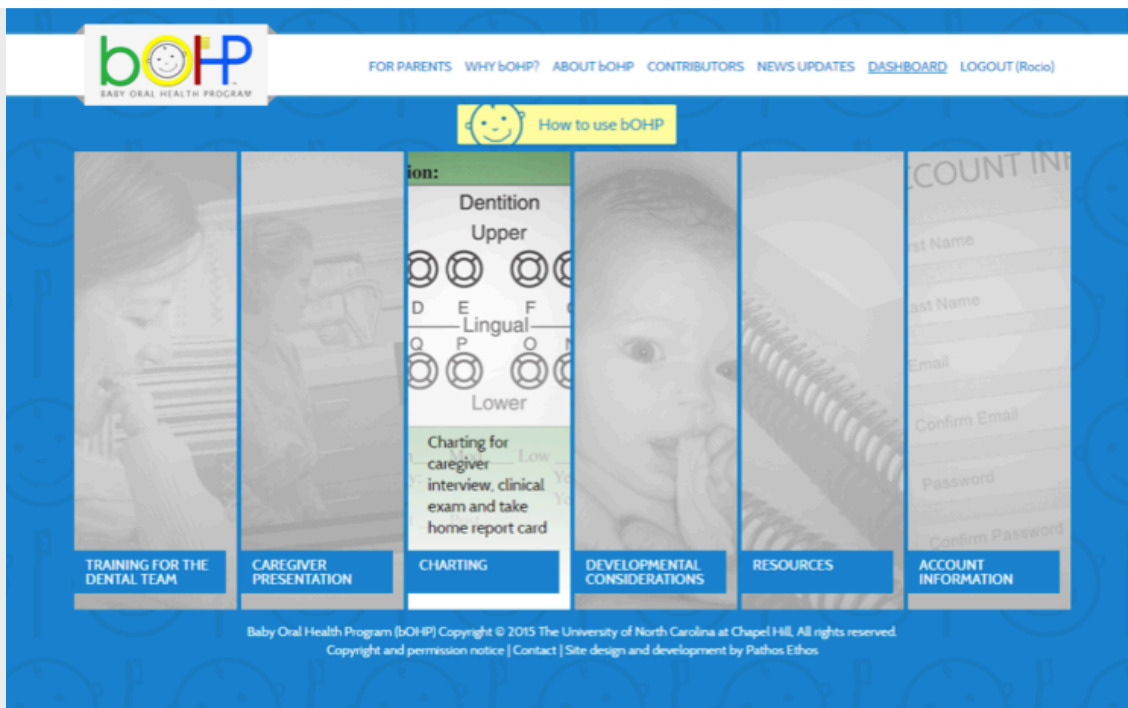
Dear bOHP Subscribers,

To improve the information covered during each bOHP visit, we have made some edits to the [Caregiver Interview](#) and [Clinical Charting](#) found in the "[CHARTING](#)" panel. We have also updated the [bOHP Report Card](#) with a color-coded caries risk assessment to allow caregivers to better visualize their child's risk as it relates to your oral health recommendations.

Check out a copy of the changes at the end of this message. We hope they will help to better capture the essence of the visit and facilitate your communication with caregivers about their infant/toddler.

Best Wishes,  
The bOHP Team





You can access the "Charting" panel via the Dashboard.

## Caregiver Interview

Name \*

Date \*

### General Health

	Yes	No
Special health care needs	<input type="radio"/>	<input checked="" type="radio"/>
Premature ( $\leq$ 36 weeks)	<input type="radio"/>	<input checked="" type="radio"/>
Saliva reducing factors (meds)	<input type="radio"/>	<input checked="" type="radio"/>

### Feeding Practice

	Yes	No	N/A	Till Age?
Breast Fed	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	N/A <input type="text"/>
Bottle Fed	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	N/A <input type="text"/>
Sippy cup use >12m	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	
>4-6 oz juice/day	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	
Soda Use	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	
$\geq$ 3 bw meals sugar-containing snacks/beverages	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	
Sleeping w/ something other than H <sub>2</sub> O	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	
Scheduled bedtime routine	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	

### Oral Hygiene Practice

	Yes	No	N/A
Started cleaning teeth	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Difficulty cleaning teeth	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Started flossing	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Fluoride toothpaste	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

### Fluoride Exposure

	Yes	No	N/A
FI-source of drinking H <sub>2</sub> O (city, well, bottled)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Child stays outside home/FI source	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Fluoride supplements prescribed	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

### Oral Habits

	Yes	No	N/A
Finger/thumb/pacifier	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Problems with teeth noted	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Dual Habits (e.g blankets)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

### Injury Prevention

	Yes	No	N/A
History of dental trauma	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Coffee table/fireplace hearth protected	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Bathtub nozzle covered	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

### Family Dent History

	Yes	No	N/A
Primary caregiver has active caries	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Sibling with history of caries	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Family history of missing/extra teeth	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Other dental problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

### Oral Development: Child Dent History

	Yes	No	N/A
Bite problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Tooth problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>





















## Clinical Exam

Patient: Alex

Date: 06/23/2015

Click on box that is next to the tooth letter to indicate the presence of tooth.  
Then click on one of the five regions of the tooth to change the color of the surface.  
Each click on a tooth surface will cycle through four colors which corresponds with a condition in the legend below.

■ Demineralization ■ Cavitation ■ Enamel Defects ■ Restoration

child right					top teeth	child left				
										
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A	B	C	D	E	LINGUAL	F	G	H	I	J
										
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T	S	R	Q	P		O	N	M	L	K
					bottom teeth					

Soft Tissue Pathology YES ☒ NO ☐

More Info:

Plaque Present YES ☒ NO ☐

LIGHT ☐ HEAVY ☒

Bleeding gingiva YES ☐ NO ☒

Enamel Defects YES ☐ NO ☒

Contacts Closed ANTERIOR ☐ POSTERIOR ☐

Caries Risk HIGH ☐ MOD ☐ LOW ☐

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