Child Dental History

Patient First name *

Patient Last name *

Patient Age *

Parent or guardian name *

First Last

Relationship to child *

What is your primary concern about your child's oral health? *

How would you describe your child's oral health? *

How would you describe your oral health?

How would you describe the oral health of your other children? *

Is there a family history of cavities? *

- Yes
- No

Does your child have a history of any of the following? For each Yes response, please describe.

Inherited dental characteristics *

Yes No

Mouth sores or fever blisters *

Yes No

Bad breath *

Yes No

Bleeding gums *

Yes No

Cavities/decayed teeth *

Yes No

Toothache *

Yes No

Injury to teeth, mouth or jaws *

Yes No

Clinching/grinding his/her teeth *

Yes No

Jaw joint problems (popping, etc.) *

Yes No

Excessive gagging *

Yes No

Sucking habit after one year of age *

Yes No

How often does your child brush his/her teeth? *

Does someone help your child brush? *

Yes No

How often does your child floss his/her teeth? *

Occasionally

Does someone help your child floss? *

Yes No

What type of toothbrush does your child use? *

What toothpaste does your child use? *

What is the source of your drinking water at home? *

Do you use a water filter at home? *

- ( ) Yes
- ( ) No

Please check all sources of fluoride your child receives: *

- [ ] Drinking water
- [ ] Toothpaste
- [ ] Over-the-counter rinse
- [ ] Prescription rinse/gel
- [ ] Prescription drops/tablets/vitamins
- [ ] Fluoride treatment in the dental office
- [ ] Fluoride varnish by pediatrician/other practitioner
- [ ] None
- [ ] Other

Does your child regularly eat 3 meals each day? *

- ( ) Yes
- ( ) No

Is your child on a special or restricted diet? *

- ( ) Yes
- ( ) No

Is your child a 'picky eater'? *

- ( ) Yes
- ( ) No

Does your child have a diet high in sugars or starches? *

- ( ) Yes
- ( ) No

Do you have any concerns regarding your child's weight? *

- ( ) Yes
- ( ) No

How frequently does your child have the following?

Candy or other sweets *

Product

Chewing gum *

Chewing gum type

Snacks between meals *

Usual snack

Soft drinks such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks) *

Product

Please note other significant dietary habits

Does your child participate in any sports or similar activities? *

Yes No

Does your child wear a mouthguard during these activities? *

Yes No

Has your child been examined or treated by another dentist? *

Yes No

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? *

Yes No

Has your child ever had a difficult dental appointment? *

Yes No

How do you expect your child will respond to dental treatment? *

Is there anything else we should know before treating your child? *

Yes No

Continue