



Oral Health Questionnaire For \_\_\_\_\_ Age: \_\_\_\_\_

Filled Out by: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Health History	Y	N	N/A	Comments
Did birth mother have problems during pregnancy?				
Was child premature and/or have low birth weight/ complications at birth?				
<b>Diet and Nutrition</b>				
Is/was the child breast fed? If so, for how long?				
Does child sleep with a bottle? (if applicable)				
How many times does child have: Something to drink each day? _____ times. Snacks each day? _____ times				
Is child on a special diet?				
<b>Fluoride Adequacy</b>				
What is child's source of water (well, tap, bottled, etc)				
Do you use fluoride toothpaste for the child? Date started?				
<b>Oral Habits</b>				
Does child use a pacifier? (If applicable)				
Does child suck a thumb or fingers?				
Does child grind his/her teeth day or night?				
<b>Injury Prevention</b>				
Do you use a car seat for child? (If applicable)				
Does the child play sports? (If applicable) Use mouthguard? Y N				
Has child had an injury to his/her mouth or face?				
<b>Oral Development and Dental History</b>				
Child's age (in months) when the first tooth came in? _____				
Have you noticed any problems with child's mouth/teeth?				
Does child complain of mouth pain?				
Have any of your children ever had cavities?				
Do you have any cavities?				
Do your gums bleed?				
Have you or anyone in your family had extra or missing teeth? Y N				
Have you or your children ever had a bad dental experience?				
<b>Oral Hygiene</b>				
How often does child brush each day? _____ Floss? _____				
Do you help child brush? _____ Floss? _____				