Pediatric
DENTAL SPECIALISTS, P.A.
CREATING SOMETHING TO SMILE ABOUT!

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?				
Diet and Nutrition				
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?				
Fluoride Adequacy				
What is child's source of water (well, tap, bottled, etc)				
Do you use fluoride toothpaste for the child? Date started?				
Oral Habits				
Does child use a pacifier? (If applicable)				
Does child suck a thumb or fingers?				
Does child grind his/her teeth day or night?				
Injury Prevention				
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?				
Oral Development and Dental History				
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?				
Oral Hygiene				
How often does child brush each day? _____ Floss?_____				
Do you help child brush? _____ Floss?_____				