**Children’s Dental History**

Date \_\_\_\_\_\_\_\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age \_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Here Today\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please estimate your child’s daily exposure to the following items:**

Soda \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cereal Bars/Granola Bars \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dried Fruit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Juice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gummies/Gummy Vitamins \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cookies/Crackers \_\_\_\_\_\_\_\_\_\_

Sports Drinks \_\_\_\_\_\_\_\_\_\_\_\_\_ Fruit Snacks/Fruit Roll-Ups \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your child: \_\_\_\_ Breast Fed What age did they stop \_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_ Bottle Fed What age did they stop \_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_ Sleep with or go to bed with a milk bottle?

\_\_\_\_ Yes \_\_\_\_ No Has your child ever been to the dentist? Date of Last X-Rays \_\_\_\_\_\_\_\_\_\_\_\_

 Name of Dentist and Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Yes \_\_\_\_ No Has your child had any dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Yes \_\_\_\_ No Has your child experienced any unfavorable reaction or anxiety to previous dental care?

\_\_\_\_ Yes \_\_\_\_ No Has your child ever used nitrous oxide (laughing gas) or sedation for dental treatment?

 If yes, did they tolerate it well and at what age? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child suck a finger, thumb or pacifier? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have pain with chewing, or going to sleep at night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any trauma to their teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check if your child is having problems with any of the following:**

\_\_\_\_\_ Cavities \_\_\_\_\_ Toothache \_\_\_\_\_ Sensitive Teeth \_\_\_\_\_ Broken Teeth

\_\_\_\_\_ Trauma to Teeth \_\_\_\_\_ Gum Infection \_\_\_\_\_ Color of Teeth \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Yes \_\_\_\_ No Has your child been treated or evaluated by an orthodontist?

 Name of Orthodontist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Yes \_\_\_\_ No Is your home water supply fluoridated?

\_\_\_\_ Yes \_\_\_\_ No Does your child use fluoride toothpaste or a fluoride mouth rinse?

\_\_\_\_ Yes \_\_\_\_ No Does your child wear retainers or sports guard?

\_\_\_\_ Yes \_\_\_\_ No Is your child or a direct family member congenitally missing teeth?

\_\_\_\_ Yes \_\_\_\_ No Does your child brush twice daily? (With parent help? \_\_\_\_ Yes \_\_\_\_ No)

\_\_\_\_ Yes \_\_\_\_ No Does your child floss once per day? (With parent help? \_\_\_\_ Yes \_\_\_\_ No)

\_\_\_\_ Yes \_\_\_\_ No Would you like your child or parent to have instructions on how to clean their teeth?

What is your child’s favorite character or favorite sport or activity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_