

## DENTAL HEALTH QUESTIONNAIRE

PATIENT'S NAME \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

- I. Present complaint/what is the problem? \_\_\_\_\_
- II. What are we doing today? \_\_\_\_\_
- III. When was the last comprehensive dental examination? \_\_\_\_\_ X-RAYS? Yes \_\_\_ No \_\_\_
  - a. Who was D.D.S.? \_\_\_\_\_
  - b. What services were performed at that time? \_\_\_\_\_
  - c. Were there any problems in completing treatment? Yes \_\_\_ No \_\_\_  
What, if any? \_\_\_\_\_
  - d. Have any teeth been removed? Describe, if Yes. \_\_\_\_\_ Yes \_\_\_ No \_\_\_
  - e. Was a space maintainer placed? Describe, if No. \_\_\_\_\_ Yes \_\_\_ No \_\_\_
  - f. Has there been any history of injury to the teeth? Yes \_\_\_ No \_\_\_  
What teeth were injured? \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_ Treatment \_\_\_\_\_
  - g. Have you been informed of any missing or extra permanent teeth? Yes \_\_\_ No \_\_\_
  - h. Has your child had Nitrous Oxide (laughing gas, sweet air)? Yes \_\_\_ No \_\_\_
  - i. Is your child nervous or frightened during dental visits? If yes, please circle:  
Least Nervous 0 1 2 3 4 5 6 7 8 9 10 Most Nervous
  - j. How would you describe your child's temperament? \_\_\_\_\_
- IV. Does your child take fluoride supplements? Yes \_\_\_ No \_\_\_
 

Topical applications to teeth \_\_\_\_\_ How often? \_\_\_\_\_ Date of last one \_\_\_\_\_  
Drops or tablets \_\_\_\_\_ How often? \_\_\_\_\_ How many? \_\_\_\_\_

  - a. Does your child take a vitamin supplement? Brand: \_\_\_\_\_ Yes \_\_\_ No \_\_\_
  - b. Are you aware if this vitamin supplement contains fluoride?  
(YES it does) \_\_\_ (NO it does not) \_\_\_ (I'm not sure) \_\_\_
  - c. Have you ever been shown how to floss and brush your child's teeth? Yes \_\_\_ No \_\_\_
  - d. How often does your child brush his/her teeth? \_\_\_ times/day. When? \_\_\_ After each meal? \_\_\_
  - e. How often does your child floss his/her teeth? \_\_\_ times/day. Brand of toothpaste used \_\_\_\_\_
  - f. Do you use town water? \_\_\_ Well water? \_\_\_ Bottled water? \_\_\_
  - g. If well or bottled, has water been tested for fluoride? \_\_\_\_\_ Yes \_\_\_ No \_\_\_  
Results? \_\_\_\_\_
  - h. How was this child fed after birth (bottle, breast, milk, formula)? \_\_\_\_\_ Type of formula: \_\_\_\_\_
  - i. Did your child tolerate milk and other foods well? \_\_\_\_\_ Yes \_\_\_ No \_\_\_
  - j. Did your child go to sleep with a bottle or while nursing? Yes \_\_\_ No \_\_\_  
At bed or nap time? \_\_\_\_\_
  - k. At what age did your child completely give up the bottle? \_\_\_\_\_
  - l. Was a pacifier used as an infant? Yes \_\_\_ No \_\_\_ Is it still being used? Yes \_\_\_ No \_\_\_
- V. Does your child have any speech problems? Describe, if Yes: \_\_\_\_\_ Yes \_\_\_ No \_\_\_
  - a. Does your child have any habits which may affect the teeth or mouth? (✓) Check if Yes.  
Breathes through mouth \_\_\_\_\_ Sucks thumbs or fingers \_\_\_\_\_ Bruxer \_\_\_\_\_  
Bite fingernails \_\_\_\_\_ Grinds teeth \_\_\_\_\_ Other \_\_\_\_\_  
Tongue habit \_\_\_\_\_ Gagger \_\_\_\_\_
  - b. Does your child experience pain in the jaws or experience headache while chewing? Yes \_\_\_ No \_\_\_
  - c. Are there any unusual sounds in ear (clicking) during eating or pain in the region of the ear? Yes \_\_\_ No \_\_\_
  - d. Has your child ever had an orthodontic examination/orthodontic treatment? Yes \_\_\_ No \_\_\_
  - e. Has your child had any unfavorable medical or dental experience? Yes \_\_\_ No \_\_\_  
If so, please explain \_\_\_\_\_
  - f. Are you interested in complete care for your child? Yes \_\_\_ No \_\_\_
  - g. It would be helpful if you would indicate below what things you are looking for most in choosing a pediatric dentist. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_