CHILD'S DENTAL HISTORY

Date of last visit to a dentist____

For what service____

____

	Yes	No
Has child complained about dental problems________________________	☐	☐
Any unhappy dental experiences_____________________________	☐	☐
Any injuries to mouth - teeth - head__________________________	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, nursing bottle habits, etc.___________________________	☐	☐
Any unusual speech habits_______________________________	☐	☐
Any lost teeth____	☐	☐
Have missing teeth been replaced__________________________	☐	☐
Orthodontic appliances worn now or ever been_________________	☐	☐
Does your child brush teeth daily__________________________	☐	☐
Do you assist child with tooth brushing______________________	☐	☐
How often____		
Is dental floss used_____________________________________	☐	☐
How often____		
Is fluoride taken in any form______________________________	☐	☐

Child's attitude to dentistry______________________________