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Sea of Smiles
Pediatric Dentistry

Patient Name	❑ Male ❑ Female	Date of Birth

SUPPLEMENTAL HISTORY QUESTIONS FOR AN INFANT/TODDLER (please complete for 0-4 years):

Was your child born prematurely? ……. ❑ YES ❑ NO If YES, what week? _____

What was your child's birth weight? _____

How long was your child breast-fed? ..... ❑ N/A ❑ less than 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

How long was your child bottle-fed? ……..... ❑ N/A ❑ less than 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

Do/did you feed your child infant formula? ……... ❑ YES ❑ NO If YES, what type? ❑ Ready to use ❑ Powdered ❑ Liquid concentrate

Does/did your child sleep with a bottle? …… ❑ YES ❑ NO If YES, content of bottle? _____

Does/did your child use a no-spill training cup (sippy cup)? ……. ❑ YES ❑ NO

Child's age (in months) when first tooth appeared in mouth _____

Has your child experienced any teething problems? …….. ❑ YES ❑ NO

When did you begin brushing his/her teeth? …….. ❑ N/A ❑ less than 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

When did you begin using toothpaste? ……. ❑ N/A ❑ less than 6 months ❑ 6-11 months ❑ 12-17 months ❑ 18-23 months ❑ 2 years or more

Who is your child's primary care taker during the day? _____ during the evening? _____

_____ _____ _____
Signature of parent/guardian Relationship to child Date

SUPPLEMENTAL HISTORY QUESTIONS FOR AN ADOLESCENT PATIENT (to be completed by the patient 12 years and older):

Do you have any concerns about your mouth, teeth or oral health? ……. ❑ YES ❑ NO If YES, describe:_____

Have you recently experienced any dental/oral pain? …….. ❑ YES ❑ NO If YES, describe:_____

Do you have any concerns with the appearance of your teeth or smile? .. ❑ YES ❑ NO If YES, describe:_____

Do you bleach your teeth? ……. ❑ YES ❑ NO If YES, how often: _____

Have there been any recent changes in your dietary habits? …….. ❑ YES ❑ NO If YES, describe:_____

Are you taking any dietary or herbal supplements? …….. ❑ YES ❑ NO If YES, describe:_____

Do you participate in contact sports or high speed sports (skiing, motorcycles)? …… ❑ YES ❑ NO If YES, describe:_____
_____

Signature of Parent/Guardian _____ **Relationship to Patient** _____

Print Name _____ **Date** _____