Fales Pediatric Dentistry Dental Questionnaire
Birth to 7 year old

Patient Name	DOB	Assessment Date

To help us assess your child's dental needs, please answer these questions. Thank you.

HEALTH HISTORY	**YES**	**NO**
Did birth mother have any health problems during pregnancy?	☐	☐
Has your child needed frequent use of liquid medication?	☐	☐
Have the parents/caregiver seen a dentist in the last year?	☐	☐
For? _____		

DIET AND NUTRITION		
Is/was your child breastfed?	☐	☐
Does your child use a bottle??	☐	☐
Does your child use a sippy cup?	☐	☐
Is your child on a special diet?	☐	☐
Describe: _____		

FLUORIDE ADEQUACY		
Do you have well water?	☐	☐
If yes, has the water been tested for fluoride content?	☐	☐
Test results: _____		

ORAL HABITS		
Does your child have any oral habits?	☐	☐
Explain: _____		

ORAL DEVELOPMENT		
Does your child have teeth?	☐	☐
Child's age (in months) when first tooth erupted? _____	☐	☐
Has your child experienced any teething problems?	☐	☐
Explain: _____		

ORAL HYGIENE		
Do you clean your child's teeth/gums?	☐	☐
Does your child's caretaker clean your child's teeth/gums?	☐	☐
Do you use a toothbrush to clean your child's teeth?	☐	☐
Do you use toothpaste to clean your child's teeth?	☐	☐
Is the toothpaste fluoridated?	☐	☐
Do you, your significant other/caretaker have untreated dental needs?	☐	☐
If yes, who? _____		

PLEASE INDICATE YOUR RELATIONSHIP TO THIS CHILD

Mother Father Guardian Signature:_____ Date: _____