The Art of Modern Dentistry

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INFANT HEALTH HISTORY UPDATE

Child's Name: _____ Birthdate: _____
Address: _____ Phone: _____
Child's Physician: _____ Phone: _____
Date of Last Physical Examination: _____

DENTAL HEALTH QUESTIONNAIRE FOR INFANT EXAM

Yes No Is the infant under the care of a physician now? If yes, please explain: _____
_____

Yes No Does the child have good physical coordination? _____
Yes No Is the child receiving any medications or drugs? _____
_____

Yes No Is your child using a bottle or sippy cup?
Yes No Is your child put to bed with a bottle?
Yes No Is your child allowed to carry a bottle or cup throughout the day containing something other than plain water? If yes explain: _____
Yes No Are you nursing?
Yes No Is your child using a pacifier?
If your child snacks during the day, what does he/she eat? _____

HOME DENTAL CARE

Yes No Does your child brush his/her own teeth?
Yes No Do you brush your child's teeth? Times per day _____
Yes No Does your child take fluoride drops or tablets? If yes, at what age did he/she start taking them? _____

HABITS

Yes No Does your child suck his/her thumb or finger?
Yes No Does your child grind his/her teeth?
Yes No Does your child have any other tooth-related habits such as chewing or sucking on a blanket, hand or toy?
If yes, please explain: _____

Any other conditions not listed? _____
_____

HAS THE CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

____ Anemia	____ Cerebral Palsy	____ Diabetes	____ Kidney	____ Mononucleosis
____ Asthma	____ Chicken Pox	____ Epilepsy	____ Liver	____ Mumps
____ Autism	____ Chronic Sinus	____ Heart	____ Rheumatic Fever	____ Thyroid
____ Seizures	____ Hearing	____ Malignancies		

Is there anything else you would like to add about the care of your child's teeth at home or any other questions you have? _____
_____

Dr. signature: _____ Date: _____

Parent/guardian signature: _____ Date: _____