Dr. John A. Hendry & Associates

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A PROFESSIONAL DENTAL CORPORATION

Dental History

What is your primary concern about your child's oral health?_____
How would you describe:

your child's oral health?	□ Excellent	□ Good	□ Fair	□ Poor
your oral health?	□ Excellent	□ Good	□ Fair	□ Poor
the oral health of your other children?	□ Excellent	□ Good	□ Fair	□ Poor

Is there a family history of cavities? □ YES □NO
Does your child have a history of any of the following? For each YES response, please describe:

Inherited dental characteristics	□YES	□NO _____
Mouth sores or fever blisters	□YES	□NO _____
Bad breath	□YES	□NO _____
Bleeding gums	□YES	□NO _____
Cavities/decayed teeth	□YES	□NO _____
Toothache	□YES	□NO _____
Injury to teeth, mouth, or jaws	□YES	□NO _____
Clinching/grinding teeth	□YES	□NO _____
Jaw joint problems (popping, etc.)	□YES	□NO _____
Excessive gagging	□YES	□NO _____
Sucking habit after one year of age	□YES	□NO _____

If yes, which: □Finger □Thumb □Pacifier □Other
For how long? _____

How often does your child brush his/her teeth? _____ times per _____
Does someone help your child brush? □ YES □ NO
How often does your child floss his/her teeth? □ Never □ Occasionally □ Daily
Does someone help your child floss? □ YES □ NO
What type of toothbrush does your child use? □ Hard □ Medium □ Soft □ Unsure
What type of toothpaste does your child use? _____
What is the source of your drinking water at home? □ City/community supply □Private well □ Bottled water
Do you use a water filter at home? □ YES □ NO
Please check all sources of fluoride your child receives:
□ Drinking water □ Toothpaste □ Over-the-counter rinse □Prescription rinse/gel
□ Prescription drops/tablets/vitamins □ Fluoride treatment in the dental office
□ Fluoride treatment by pediatrician/other practitioner
Does your child regularly eat 3 meals a day? □ YES □ NO
Is your child on a special or restricted diet? □ YES □ NO
Does your child have a diet high in sugars or starches? □ YES □ NO
Do you have any concerns regarding your child's weight? □ YES □ NO
How frequently does your child have the following?

Candy or other sweets	□ Rarely	□ 1-2 times/day	□ 3 or more times/day
Chewing gum	□ Rarely	□ 1-2 times/day	□ 3 or more times/day
Snacks between meals	□ Rarely	□ 1-2 times/day	□ 3 or more times/day
Soft drinks	□ Rarely	□ 1-2 times/day	□ 3 or more times/day

(such as juice, fruit-flavored drinks, sodas, carbonated beverages, sports drinks, energy drinks)

Please note any other significant dietary habits: _____

Does your child chew ice, bite his/her fingernails, or any other habits? _____

Does your child participate in any sports or physical activities? □ YES □ NO If YES, list:_____

Does your child wear a mouthguard during these activities? □ YES □ NO If YES, what type?_____

Has your child been examined or treated by another dentist? □ YES □ NO

If YES, date of last visit:_____ Reason for last visit:_____

Were x-rays taken of the teeth or jaws? □ YES □ NO Date of most recent x-rays:_____

Has your child ever had orthodontic treatment? □ YES □ NO If YES, when? _____

Has your child ever had a difficult dental appointment? □ YES □ NO If YES, describe:_____

_____

How do you expect your child will respond to dental treatment? □ very well □ fairly well □ somewhat poorly □ very poorly

Does your child have any special interests? _____

Is there anything else we should know before treating your child? □ YES □ NO

If yes, describe: _____

_____ _____ _____ _____

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