Dr. John A. Hendry & Associates

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Pediatric Dentists
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General Dentists
A PROFESSIONAL DENTAL CORPORATION

Supplemental History for Infants/Toddlers

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

Does/did your child sleep with a bottle? □YES □NO If YES, contents of bottle:_____

Does/did your child use a sippy cup? □YES □NO

Does/did your child have any habits such as thumb, finger, or pacifier-sucking? _____

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? _____ When did you begin using toothpaste?_____

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

Name/age of siblings at home:_____

_____

_____ _____ _____ _____

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