Initial Oral Health Questionnaire

Patient Name: _____ Date of Birth: _____

History

Problems during pregnancy? Y N If yes, what? _____
Premature? Y N If yes, how many weeks? _____ Birth weight: _____
Complications at birth? Y N If yes, what? _____

Infant Illnesses/ frequency? _____
Medications / frequency? _____
Medical allergies: _____

Diet and Nutrition

Nursing? Y N If no, when stopped? _____ Night-time? Y N
Bottle-fed? Y N If no, when stopped? _____ Night-time? Y N
Sippie-cup? Y N If no, when stopped? _____ Night-time? Y N
Does patient drink soda/soft drinks? Y N If yes, how often? _____

Fluoride Adequacy

Well water or city water?_____ Bottled water? Y N
Fluoride supplements? Y N If yes, who prescribed them and dosage?_____
Fluoridated toothpaste used at home? Y N If yes, does patient swallow it? Y N
Does patient use a fluoride rinse? Y N If yes, does patient swallow it? Y N

Oral Hygiene (please circle choice)

Who brushes patient's teeth? Patient Parent Both
Type of toothbrush? Manual Electric Uses both
How often are patient's teeth brushed? Twice/day Once/day Less than once/day
Are patient's teeth flossed? Y N Who flosses? Patient Parent Both
How often are patient's teeth flossed? Twice/day Once/day Less than once/day
Does patient use disclosing tablets? Y N
Have you received instructions on proper brushing technique? Y N

Habits

Pacifier? Y N If no, when discontinued? _____ If yes, when used? Day Night Both
Thumb or finger habit? Y N If no, when discontinued? _____
Nail biting? Y N Mouth-breathing? Y N
Does patient grind their teeth? Y N If yes, how often? Sometimes All of the time

Injury Prevention/ History of Trauma

Is home child-proofed? Y N Does child ride in a car seat? Y N
Has patient had trauma to their mouth or head? Y N
If yes to trauma, when? _____ What happened?_____
If yes to trauma, was treatment seeked?_____

Oral Development

At what age did patient's first tooth come in? _____ Any family history of tooth problems (ie missing teeth, too many teeth, enamel hypoplasia)? Y N If yes, what is problem and how is person related to patient? _____
Does patient currently have tooth or mouth pain? Y N If yes, for how long?_____

Office use: Water tested: date_____ Results _____ Supplement: Y N Dosage___