**CPD DENTAL HISTORY FORM**

Patient Name:

Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_ Preferred \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1.** What is the Primary concern about your child's oral health?

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**2.** How would you describe your child's oral health?

Excellent Good Fair Poor

**3.** How would you describe your oral health?

Excellent Good Fair Poor

**4**. How would you describe the oral health of your other children?

Excellent Good Fair Poor Not Applicable

**5.** Is there a family history of Cavities?  Yes No

**6**. If Yes, please check all that apply.  Mother  Father Brother  Sister

**7.** Does your child have a history of any of the following? Check all that apply.

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| --- | --- | --- | --- |
| Inherited Dental Characteristics |  | Injury to teeth, mouth, or jaws |  |
| Mouth Sores or Fever Blisters |  | Clinching/Grinding their teeth |  |
| Bad Breath |  | Jaw joint problems (popping, etc.) |  |
| Bleeding Gums |  | Excessive Gagging |  |
| Cavities/decayed teeth |  | Sucking habits after one year of age |  |
| Toothache |  |  |  |

**8.** If yes to any of the answers to question 7, please describe

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**9**. How often does your child brush their teeth?

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**10**. Does someone help your child brush?  Yes  No

**11**. How often does your child floss their teeth?

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**12**. Does someone help your child floss their teeth?  Yes  No

**13**. What type of toothbrush does your child use?  Hard Medium Soft Unsure

**14.** What toothpaste does your child use?

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**15.** What is the source of your Drinking water at home?

City/Community Supply Private Well  Bottled Water

**16.** Do you use a water filter at home? If yes, what type of filtering system?

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**17**. Please check all sources of fluoride your child receives.

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| --- | --- | --- | --- |
| Drinking Water |  | Toothpaste |  |
| Over-the-counter rinse |  | Prescription rinse/gel |  |
| Prescription drops/tablets/vitamins |  | Fluoride treatment in the dental office |  |
| Fluoride Varnish by pediatrician/other practitioner |  |  |  |

**18**. Does your child regularly receive 3 meals a day?  Yes  No

**19**. Is your child on a special or restricted diet? If yes, please describe.

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**20**. Is your child a 'picky eater'? If yes, please describe.

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**21**. Does your child have a diet high in sugars/starches? If yes, Please describe.

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**22**. Do you have any concerns regarding your child's weight? If yes, Please describe.

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**23**. How frequently does your child snack between meals?

Never Rarely 1-2 times/day 3 or more/day

**24**. What type of snacks does your child usually have?

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**25**. How frequently does your child have candy or other sweets?

Never Rarely 1-2 times/day 3 or more/day

**26**. How frequently does your child have Chewing gum?

Never Rarely 1-2 times/day 3 or more/day

**27**. How Frequently does your child have soft drinks? (such as juice, fruit-flavored drinks, soda, Carbonated beverages, Sweetened beverages, sports drinks, or energy drinks)

Never Rarely 1-2 times/day 3 or more/day

**28**. Please note any other significant dietary habits

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**29**. Does your child participate in any sports or similar activities? If yes, please list

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**30**.Does your child wear a mouthguard during these activities? If yes, what type?

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**31**. Has your child been examined by another dentist? If yes,

Date of first visit: Date of last visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Last visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were X-rays taken? \_\_\_\_\_\_\_\_\_\_\_\_\_ When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**32**. Has your child ever had a difficulty dental appointment? If yes, please describe.

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**33**. How do you expect your child will respond to dental treatment?

Very well Fairly well Somewhat poorly Very Poorly

**34**. Is there anything else we should know before treating your child?

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