Dental History under 6 years of age

Name_____ Today's Date_____

Date of Birth_____

Please circle Y or N

Are you presently in any dental pain?	Y	N
Have you ever experienced an unfavorable reaction to dentistry?	Y	N
Have you had any injuries to face, mouth or teeth?	Y	N
Do your gums bleed when you brush?	Y	N
Do you have a tongue or thumb habit?	Y	N
Are you a mouth breather?	Y	N
Are you aware of clenching your teeth during the day?	Y	N
Does your Mother or primary caregiver and/or siblings have active decay?	Y	N
Do you eat or drink sugary foods between meals? (Juice, soft drinks, energy drinks, medicinal syrups)	Y	N
Do you or did you use sippy cups with anything but water?	Y	N
Do you or did you go to bed with a bottle with anything but water?	Y	N
Are you eligible for Government programs? (WIC, Head Start, Medicaid or SCHIP)	Y	N
Do you notice plaque build up on teeth between brushings?	Y	N
Have you had a new cavity in the last 24 months?	Y	N
Do you have Special Health Care Needs (developmental, physical, medical or mental disabilities that prevent or limit performance of Adequate oral health care by themselves)	Y	N
Do you have Sleep Apnea?	Y	N
Do you use a CPAP machine?	Y	N

If so how often? _____