Parent Questionnaire: Child 5 years and under

Please answer the following questions about your child so that we may provide the best dental care possible

Child's Name: _____ Date:_____

Oral Hygiene

How often does your child brush? _____ per day/week
How often does your child floss? _____per day/week
Does your child clean his/her own teeth? Yes No
Does Mom or Dad help? Yes No
What kind of toothpaste or other oral products do you use? _____
_____
Does anyone in the family have untreated dental decay? Yes No

Diet

How many times a day does your child eat? _____ meals _____ snacks _____sugary treats
What are his/her favorite foods?
_____
_____
_____

How often does your child drink sugared beverages?
Soda _____ per day/week
Juice _____ per day/week
Sports drinks _____ per day/week
Chocolate milk _____ per day/week
Is/ was your child breastfed? Yes No Until what age? _____
Does your child use a bottle? Yes No
Does your child go to bed with a bottle? Yes No What does it contain? _____
Does your child use a sippy cup? Yes No
Do you have fluoridated water? Yes No Unsure

Habits

Does your child have any of the following habits:
Thumb or finger sucking? Yes No
Pacifier use? Yes No
Nail biting? Yes No
Other? _____
_____