



**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

### **DENTAL HEALTH QUESTIONNAIRE FOR CHILDREN OVER 5**

A child's dental health is affected by many different things. The three most important to developing teeth are home care (tooth brushing, flossing and the use of fluoride), any habits relating to the mouth or teeth, and your child's diet. To help us better evaluate your child's dental health, please answer the following questions:

#### **HOME DENTAL CARE**

1. Does your child brush his/her own teeth? YES NO  
How often? \_\_\_\_\_ times per day \_\_\_\_\_ times per week
2. Do you brush your child's teeth? YES NO  
How often? \_\_\_\_\_ times per day \_\_\_\_\_ times per week
3. How much toothpaste do you use? \_\_\_\_\_
4. Does your child swallow it? YES NO
5. Does your child use dental floss? YES NO  
If yes, how often? \_\_\_\_\_ times per day \_\_\_\_\_ time per week
6. Do you floss your child's teeth? YES NO  
If yes, how often? \_\_\_\_\_ times per day \_\_\_\_\_ times per week \_\_\_\_\_ times per month
7. Does your child take fluoride drops or tablets? YES NO  
If yes, at what age did he/she start taking them? \_\_\_\_\_  
Is he/she still taking them? YES NO
8. Has you child ever lived in a fluoridated area? YES NO  
If yes, what age? \_\_\_\_\_ How long? \_\_\_\_\_
9. Does your child use a fluoride mouthwash? YES NO  
If yes, at school \_\_\_\_\_ at home \_\_\_\_\_ brand name \_\_\_\_\_

10. Has your child received fluoride treatments at a dental office? YES NO

11. Anything else you would like to add about the care of your child's teeth at home?

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**HABITS**

1. Did/does your child suck his/her thumb or finger? YES NO

Stopped at age \_\_\_\_\_ Still does \_\_\_\_\_ Only at night \_\_\_\_\_

2. Does your child chew ice? YES NO

3. Does your child grind his/her teeth? YES NO

4. Does your child have any other tooth related habits?

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**DIET**

1. How many meals per day does your child eat? \_\_\_\_\_

2. How many between meal snacks (including drinks other than water) does your child have on an average day? \_\_\_\_\_

3. Does your child chew gum with sugar in it? YES NO

If yes, how often? \_\_\_\_\_ times per day \_\_\_\_\_ times per week

4. Does your child have raisins, fruit rollups, fruit wrinkles, candy in small pieces, breath mints, or suckers? YES NO

If yes, please circle the ones that are applicable.

5. Would you like to make any comments about your child's diet?

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