

Child Dental History

CHT# _____

Date _____

Is this your child's first visit to the dentist? _____

How often are your child's teeth usually examined? _____

Reason for today's visit: _____

Previous dentist _____ City/State _____

Date/Reason for last dental visit: _____

How were previous dental experiences? _____

How often does child: Brush _____ Floss _____ Use fluorides such as Act/Prevident _____

Do you help child brush each day? _____ Do you floss child's teeth? _____

Has there been any injuries to teeth, such as falls, blows, chips, etc.? _____

Are you unhappy with child's teeth? If so, why? _____

Any discomfort/swelling today..... No Yes

Teeth sensitive to hot/cold/sweets.... No Yes

Teeth sensitive to pressure/biting..... No Yes

Intense anxiety about dental care..... No Yes

Frequent mouth ulcers/cold sores..... No Yes

Do gums bleed easily..... No Yes

Has child had gum treatments..... No Yes

Gum surgery..... No Yes

Any problems with bad breath..... No Yes

Any teeth extracted..... No Yes

Any problems after extraction..... No Yes

Has child seen an orthodontist... No Yes

Has child had braces..... No Yes

Does child clench/grind teeth..... No Yes

Any TMJ/joint discomfort..... No Yes

Treatment for bite/joints..... No Yes

Is water at home "well water" No Yes

Is water a "community well" No Yes

Between meals does child:

drink beverages/soda..... No Yes

eat snacks/candy..... No Yes

chew gum/breath mints... No Yes

