Questionnaire for Patients Under the Age of 4

Patient Name ____ DOB ________________________

Y	N	Was your child born prematurely?
Y	N	Were there complications before or during birth, birth defects, syndromes, or inherited conditions?
Y	N	Has your child had problems with physical growth or development?
Y	N	Was your child breast fed? ___ Less than 6 months ___ 6-11 months ___ 12-23 months ___ 2 years or more ___ N/A
Y	N	Was your child bottle fed? ___ Less than 6 months ___ 6-11 months ___ 12-23 months ___ 2 years or more ___ N/A
Y	N	Do/did you feed your child infant formula?
Y	N	Does/did your child sleep with a bottle?
Y	N	Does your child use a no-spill training cup (sippy cup)?
Y	N	Has your child experienced any teething problems?
Y	N	Does/did your child have a sucking habit after one year of age? **If YES:** _____ Finger _____ Thumb _____ Pacifier For how long? ______________________

Child's age (in months) when tooth first appeared in mouth _________________________________

When did you start brushing your child's teeth?

___ Less than 6 months ___ 6-11 months ___ 12-23 months ___ 2 years or more ___ N/A

When did you begin using fluoridated toothpaste?

___ Less than 6 months ___ 6-11 months ___ 12-23 months ___ 2 years or more ___ N/A

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