SCHIMP
FAMILY DENTISTRY

PEDIATRIC DENTAL HISTORY

Ages 0-13

Child's Name: _____Date of Birth: _____

Former Dentist: _____

Reason for today's visit: _____

Please check any of the following conditions that apply to your child:

___Bad breath
___Bleeding gums
___Clicking or popping jaw
___Food collection between teeth
___Grinding teeth
___Pacifier Use
___Uses fluoride toothpaste or rinse
___Nursing/Breastfeeding
___Thumb or Finger sucking
___Sensitivity to cold or hot
___ Sensitivity to sweets
___ Sensitivity when biting
___ Snoring or Mouth breathing
___ Sippy Cup or Bottle Use
___ Nail Biting
___Fluoride given by Pediatrician

Frequency of sugary beverages and snacks:

(example: Breast Feeding 2-3 times daily, Juice, in a cup once daily, Milk, every morning with a bottle, Crackers daily after daycare/school)

_____
_____
_____

Anything else about your child's dental history you feel we should know about:

_____
_____

Tell us about your child's daily dental routines:

(example: brushes teeth in the morning, and we assist brushing at night with colgate toothpaste, and flosses every night before bed)

_____
_____
_____