



## 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.

Child's Name: \_\_\_\_\_

Date: \_\_\_\_\_

### HABITS

Did/does your child suck his/her thumb or finger? Yes \_\_\_ No \_\_\_

Stopped at age \_\_\_\_\_ still does \_\_\_\_\_ only at night \_\_\_\_\_

Does your child chew ice? Yes \_\_\_ No \_\_\_

Does your child grind his/her teeth? Yes \_\_\_ No \_\_\_

Does your child have any other tooth related habits? \_\_\_\_\_

### HOME DENTAL CARE

Does your child brush his/her own teeth? Yes \_\_\_ No \_\_\_  
how often? \_\_\_\_\_ times per day \_\_\_\_\_ times per week

Do you brush your child's teeth? Yes \_\_\_ No \_\_\_  
how often? \_\_\_\_\_ times per day \_\_\_\_\_ times per week

How much toothpaste do you use? \_\_\_\_\_

Does your child swallow it? Yes \_\_\_ No \_\_\_

Do you help your child use dental floss? Yes \_\_\_ No \_\_\_  
If yes, how often? \_\_\_\_\_ times per day \_\_\_\_\_ time per week

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 \_\_\_

Does your child use a fluoride mouthwash? Yes \_\_\_ No \_\_\_  
If yes, at school \_\_\_\_\_ at home \_\_\_\_\_ brand name \_\_\_\_\_

Has your child received fluoride treatments at a dental office? Yes \_\_\_ No \_\_\_



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

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**DIET**



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

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

Does your child eat raisins, fruit rollups, fruit wrinkles, candy in small pieces, breath mints, or suckers? Yes \_\_\_ No \_\_\_

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

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