Supplemental History Questions for an Infant/Toddler

Patient Name:____**Date:**__________________

Was your child born prematurely? ☐ Yes ☐ No If yes, what week?__________________________

What was your child's birth weight?_______________ Vaginal or Cesarean?_______________________

Any birth complications?____

Infants are usually given vitamin K at birth. Did your child receive the vitamin K shot? ☐ Yes ☐ No

Do/did you breastfeed? ☐ Yes ☐ No If No, was this due to latch difficulties? ☐ Yes ☐ No

How long was your child breast-fed?
☐ n/a ☐ less than 6 months ☐ 6-11 months ☐ 12-17 month ☐ 18-23 months ☐ 2 years or more

How long was your child bottle-fed?
☐ n/a ☐ less than 6 months ☐ 6-11 months ☐ 12-17 month ☐ 18-23 months ☐ 2 years or more

Do/did you feed your child infant formula? ☐ Yes ☐ No
If yes, what type? ☐ ready to use ☐ powdered ☐ liquid concentrate

Does/did your child sleep with a bottle? ☐ Yes ☐ No
If yes, content of bottle?____

Does/did your child use a no-spill training cup (sippy cup)? ☐ Yes ☐ No

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

Has your child experienced any teething problems? ☐ Yes ☐ No

When did you begin brushing his/her teeth?
☐ n/a ☐ less than 6 months ☐ 6-11 months ☐ 12-17 month ☐ 18-23 months ☐ 2 years or more

When did you begin using toothpaste with fluoride?
☐ n/a ☐ less than 6 months ☐ 6-11 months ☐ 12-17 month ☐ 18-23 months ☐ 2 years or more

Who is your child's primary caretaker during the day?_________________during the evening?_____________

Name/age of siblings at home:____

____

________________________	________________________	________________________
Signature of parent or guardian	**Relationship to patient**	**Date**

Staff Reviewing paperwork: ____