

**DENTAL HISTORY (Child 17 years or younger)**

1. Are you having pain or discomfort from your mouth at this time?

YES NO UNKNOWN WHERE \_\_\_\_\_

2. Do you feel nervous about having dental treatment?

YES NO

3. Have you ever had a bad experience in the dental office?

YES NO UNKNOWN WHEN? \_\_\_\_\_

4. Do you brush your teeth at least twice daily?

YES NO HOW OFTEN? \_\_\_\_\_

5. Do you use dental floss, a proxabrush or toothpicks?

YES NO HOW OFTEN? \_\_\_\_\_

6. Have you ever had periodontal (gum) treatment?

YES NO UNKNOWN WHEN? \_\_\_\_\_

7. When did you last have your teeth cleaned? \_\_\_\_\_

8. How often do you have your teeth cleaned in a year? \_\_\_\_\_