Dr. Renée Owen
2024 Lansing Road
Charlotte MI, 48813

Well Baby Exam Parent Questionnaire

Child's Name: ____ Age: ____________________

Child's Birth Date: ____ Date: _____________________

To help us assess your child's dental needs, please answer these questions. Thank you.

HEALTH HISTORY

Did birth mother have any problems during pregnancy?	YES	NO
Has your child needed frequent use of liquid medications?	YES	NO
Have the parents/caretaker seen a dentist in the last year?	YES	NO

DIET AND NUTRITION

Is/was your child breastfed?	YES	NO
Does your child sleep with a bottle?	YES	NO
Does your child drink from a sippy cup or cup?	YES	NO
Is your child on a special diet?	YES	NO
Do you reward your child's good behavior with treats or sweets?	YES	NO
Does your child eat raw fruits and vegetables?	YES	NO

FLUORIDE ADEQUACY

Do you have well water?	YES	NO
If yes, has the water been tested for fluoride content?	YES	NO

ORAL HABITS

Does your child have any oral habits? (Thumb sucking, etc.)	YES	NO

ORAL DEVELOPMENT

Does your child have teeth?	YES	NO

Childs age (in months) when first tooth erupted? _______________

ORAL HYGIENE

Do you and/or caretaker clean your child's teeth and gums?	YES	NO
Do you use a toothbrush to clean your child's teeth?	YES	NO
Do you use tooth paste to clean your child's teeth?	YES	NO
Do you brush your child's teeth before bedtime?	YES	NO
Do you floss your child's teeth regularly?	YES	NO
Do you/your significant other/caretaker have untreated dental needs?	YES	NO

If yes who? ___________________________________ Notes: ______________________________

What questions do you have for Dr. Owen?

1.____

2.____

Signature: ____________________________________ **Relationship to Child:** __________________