DEVELOPMENTAL HISTORY

FOR YOUNGER CHILDREN

Check Yes	Check No	
		Baby born premature
		Problem during pregnancy or delivery
		Problems immediately after birth

Check Yes	Check No	
		Rh or blood problem
		Feeding problems
		Did baby go home with mother from hospital?

FOR ALL CHILDREN

At what age did your child stand? _______ Walk _______ Talk _______

Check Yes	Check No		
		Was your child breast fed?	When stopped? ________
		Was your child bottle fed?	When stopped? ________
		Did your child use a pacifier?	When stopped? ________
		Did your child suck a finger or thumb?	When stopped? ________
		Does your child attend any special classes or schools?	What grade is your child in? ________

FOR OLDER CHILDREN AND ADOLESCENTS

Check Yes	Check No	
		Has your child recently started to grow quickly?
		Do you think your child has stopped growing?
		Do you have any records of your child's height or weight changes?
		Has your child shown any signs of reaching puberty?

(Example: Girls - monthly period; Boys - shaving or voice change)

DENTAL HISTORY

Check Yes	Check No	
		Is this your child's first visit to a dentist?
		Has your child had toothaches in past?
		Does your child have pain now?
		Has your child ever received trauma to teeth, mouth, or face?
		Does your child think anything is wrong with his/her teeth?
		Do you think your child will react negatively (be upset) to dental treatment?
		Are you nervous about this appointment?
		Does your child brush his/her own teeth?
		Does your child use dental floss?
		Do you usually help your child brush?
		Do your child's gums bleed when brushed?
		Did you or your child ever get instructions in brushing?
		Does your child use fluoride products: rinses, drops, tabs?

Type of toothpaste ________

How often are teeth brushed? ________

When are teeth brushed? ________

Does your child eat well-balanced meals? ________

What kinds of between-meal foods does your child like? ________

____

____

________ SIGNATURE OF PERSON COMPLETING HISTORY

________ RELATIONSHIP TO CHILD