

Let's Talk Teeth!

Parent's Name: _____ Child's Name: _____ Child's Age: _____

Answer the following questions about your child: (note: some questions may not apply based on the age and developmental stage of your child.)

- | | Yes | No | NA |
|---|--------------------------|--------------------------|--------------------------|
| 1. If your child has teeth, do you brush them? If YES: Times per day _____ Times of day _____ Days per week _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does your child drink anything besides water between meals and snacks? If YES: What does she drink? _____ How often? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does your child go to bed with a bottle filled with anything besides water? If YES: What type of drink? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does your child eat between meals? If YES: What does he/she eat? _____ When? (times of day) _____ How often? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does your child have a dentist? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had your child's teeth checked by a dentist or medical provider? If YES: When? _____ By whom? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does your child have cavities or pain in his/her mouth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have concerns about his/her teeth or mouth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If you are pregnant, answer the following questions:

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| 1. Do you brush your teeth? If YES: Times per day _____ Times of day _____ Days per week _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you drink anything but water between meals and snacks? If YES: What do you drink? _____ How often? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you eat between meals? If YES: What? _____ When? (times of day) _____ How often? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have a dentist? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you seen the dentist during your pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have cavities or pain in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have concerns about your teeth or mouth? If YES: What? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

