DENTISTRY FOR CHILDREN
Shelly K. Clark, D.D.S.
211 West Belt Line Road
Cedar Hill, Texas 75104
(972)291-0111
4450 East Highway 287
Midlothian, Texas 76065
(972)723-0111
www.DrShellyClark.com

Shelly K. Clark, D.D.S.
Diplomate, American Board of Pediatric Dentistry

_____
Patient Name

SUPPLEMENTAL HISTORY QUESTIONS FOR AN INFANT/TODDLER

Was your child born prematurely? □YES □NO If YES, what week? _____

What was your child's birth weight? _____

How long was your child breast-fed? □N/A □less than 6 months □6-11 months □12-17 months □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 months □18-23 months □2 years or more

Do/did you feed your child infant formula? □YES □NO If YES, what type? (check one): □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 □before age 6 months □6-11 months □12-17 months □18-23 months □2 years or more

When did you begin using fluoridated toothpaste? □N/A □before age 6 months □6-11 months □12-17 months □18-23 months □2 years or more

Who is your child's primary care taker during the day? _____ during the evening? _____

Name/age of siblings at home: _____
_____

_____ _____ _____

Signature of parent/guardian Relationship to child Date