Well baby Exam (Ages 2 & under)

Todays Date _____

Childs Name _____ Age _____ Birthdate _____Parent/Guardian's Name _____

Address _____City _____ State _____ Zip _____

Phone: Home _____ Cell: _____ Work: _____

Insurance Co _____ Group Number _____ ID Number _____ Employer Name _____

Employee Name _____Employee Date of Birth _____ Employee Social Security No. _____

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

	Yes	No
Health History		
Did birth mother have any problems during pregnancy?	◯	◯
Notes:_____		
Diet and Nutrition		
Is/was your child breastfed?	◯	◯
Does your child sleep with a bottle?	◯	◯
Does your child drink from a sippy cup?	◯	◯
Is your child on a special diet?	◯	◯
Notes:_____		
Fluoride Adequacy		
Do you have well water?	◯	◯
Notes:_____		
Oral Habits		
Does your child suck his/her thumb, fingers or pacifier?	◯	◯
Notes:_____		
Oral Development		
Does your child have teeth?	◯	◯
Child's age (in months) when first tooth erupted?	◯	◯
Has your child experienced any teething problems?	◯	◯
Notes:_____		
Oral Hygiene		
Do you clean your child's teeth/gums?	◯	◯
Do you use a toothbrush to clean your child's teeth?	◯	◯
Do you use toothpaste to clean your child's teeth?	◯	◯
Notes:_____		

Circle: Mother Father Guardian **Signature:_____**

UPDATES

Date _____ Changes _____

Patient Signature _____ Staff _____

Date _____ Changes _____

Patient Signature _____ Staff _____