

QUESTIONNAIRE Number.....

Mark the correct answer with a cross (X) in the box (☐).

Provide a written answer in the dotted space (.....).

Personal data

Child's gender: female ☐ male ☐

Date of birth:

City of residence:.....

Oral hygiene

Does the child brush their teeth or have their teeth brushed? Yes ☐ No ☐

How often?.....

At what age did you start brushing your child's teeth?.....

Does the child use fluoride toothpaste? Yes ☐ No ☐

Dental care

Has your child visited the dentist before? Yes ☐ No ☐

When was the last dental visit?

At what age was the first dental visit?

What was the reason for the child's first dental visit?

- ☐ The onset of pain
- ☐ Parental concern about visible symptoms of tooth decay or other oral health issues
- ☐ Routine check-up

Diet

Until what age was the child breastfed? months

Until what age was the child bottle-fed? months

Does the child consume food or drinks (other than water) at bedtime? Yes ☐ No ☐

Does the child consume food or drinks (other than water) during the night? Yes ☐ No ☐

How many meals per day does the child eat (including snacks between main meals)?

How often does your child consume the following products?

[illegible]