Questionnaire about your child's dental health
1-year-8-month-old health checkup

1歳8か月児健康診査　歯科問診票

Name of child _____

【Below are questions about your child's dental health. Please circle the appropriate items, and fill in the blanks.】

1	① Does your child eat sweets almost every day?	Yes	No
	② If you chose **Yes** on ①, what kind of sweets does your child eat?	Candies, Chocolates, Gummy candies, Snack food, Others( )	
2	① Does your child drink sweet beverages (juice, soft drinks, lactic acid beverages, isotonic drinks, etc.) almostevery day?	Yes	No
	② If you chose **Yes** on ①, what kind of beverages does your child drink? *100% fruit & vegetable juice are "juice" and others are "soft drinks".	Juice, Soft drinks Lactic acid beverages, Isotonic drinks. Others( )	
	③ If you chose **Yes** on ①, how much does your child drink per day?	( ) **ml**	
3	① Does your child have a habit of falling asleep while drinking breast milk at night?	Yes	No
	② Does your child have a habit of falling asleep while drinking beverages, other than water or tea, with a baby bottle?	Yes	No
	③ If you chose **Yes** on ②, what kind of beverages does your child drink?	Milk, Juice, Soft drinks, Lactic acid beverages, Isotonic drinks, Others( )	
4	① How many times a day does your child have snacks?	Zero, Once, Twice When your child requests one	
	② Do you have a regular snack time?	Around __o'clock & __o'clock When your child requests one	
5	Do you have any questions or concerns about your child's teeth that you would like to consult with a dentist or dental hygienist? (e.g., Your child dislikes brushing teeth, or you worry about the child's bad breath, tooth alignment.)	Yes (Please describe specifically.)	No