This questionnaire refers to the parent’s oral hygiene habits

1. Compilation date:……………………………….

Parent’s date of birth:……………………………

1. What study degree have you achieved?

□ ELEMENTARY SCHOOL

□ MIDDLE SCHOOL

□ HIGH SCHOOL

□ DEGREE (Specify in which field ………………………………………………………….)

1. How many times a day do you brush your teeth?

□ 0 TIMES

□ ONCE (in the morning)

□ ONCE (In the evening)

□ TWICE (In the morning and in the evening)

□ 3 TIMES (in the morning, after lunch and in the evening)

□ OTHER ……………………………………………………………….

1. What kind of toothbrush do you use?

□ MANUAL

□ ELECTRIC

□ SONIC

1. Do you use any other homecare tool?

□ YES

□ NO

1. If YES, which one? (you can give multiple choices)

□ DENTAL FLOSS

□ MOUTHWASH

□ PICK

□ WATERPICK

□ OTHER ………………………………………………………………

1. Have you ever had dental problems?

□ YES

□ NO

1. Do you periodically visit a dentist or dental hygienist?

□ YES

□ NO

1. If YES, how often?

□ ONCE A YEAR

□ TWICE A YEAR

□ ONCE EVERY 2 YEARS

□ ONCE EVERY 3 YEARS

□ OTHER ………………………………………………………..

1. Did you learn about oral hygiene and care from…?

□ DENTIST

□ DENTAL HYGENIST

□ DENTAL ASSISTANT

□ ADVERTISEMENT

□ INTERNET

□ OTHER …………………………………………………………

This questionnaire refers to the child’s oral hygiene habits but it has to be filled by a parent.

Compilation date: …………………………………….…...

Child’s date of bith: …………………………………….…...

Sex: □MALE □FEMALE

1. Does your child brush his/her teeth?

□ YES

□ NO

1a) If YES, he/she brushes them:

* BY HIMSELF
* HELPED BY A PARENT
* BOTH

1. How many times a day does he/she brushes his/her teeth?

□ 0 TIME

□ ONCE (In the morning)

□ ONCE (In the evening)

□ TWICE (In the morning and in the evening)

□ 3 TIMES (in the morning, after lunch and in the evening)

□ OTHER ……………………………………………………………….

1. What kind of toothbrush does he/she use?

□ MANUAL

□ ELECTRIC

1. Is it a toothbrush suitable for kids?

□ YES

□ NO

□ I DON’T KNOW

1. Does your child use a toothpaste while brushing?

□ YES

□ NO

1. If YES, does it contain fluoride?

□ YES

□ NO

□ I DON’T KNOW

1. Is it a toothpaste suitable for kids?

□ YES

□ NO

□ I DON’T KNOW

1. Have you ever brought your child to the dentist?

□ YES

□ NO

8a) If YES, at what age did your child went for his/her first dental visit? ..............

8b) Who suggested you to take him to the dentist the first time?

* DENTIST
* HYGENIST
* PEDIATRICIAN
* TEACHER
* FRIEND
* OTHER ……………………………………………………..

8c) Why did you bring him/her to the dentist?

* TOOTHACHE
* TOOTH TRAUMA
* TOOTH MALPOSITION
* CHECK UP

1. Has your child ever had dental problems from caries?

□ YES

□ NO

□ I DON’T KNOW

1. Does your child take fluoride supplements?

□ YES

□ NO

□ I DON’T KNOW

1. Is your child still breastfed?

□ YES □ NO

1. If your answer is NO, at what age (in months) did you stop it? …………………………………………………………….
2. During the night your child slept/sleep with the bottle?

□ YES

□ NO

This questionnaire refers to the child’s eating habits but it has to be filled by a parent.

1) Does your child eat breakfast?

□ YES

□ NO

□ SOMETIMES

What does he/she usually eat? ………………………………………………………………………………………………………………………………………

2) Does your child eat a morning snack?

□ YES

□ NO

□ SOMETIMES

What does he/she usually eat? ………………………………………………………………………………………………………………………………………

3) Does your child eat an afternoon snack?

□ YES

□ NO

□ SOMETIMES

What does he/she usually eat? ………………………………………………………………………………………………………………………………………

4) Does your child eat an evening snack (he/she eats something 30 minutes or more after dinner)?

□ YES

□ NO

□ SOMETIMES

What does he/she usually eat? ………………………………………………………………………………………………………………………………………

5) How many times a week does your child eat these foods? Consider a week made by 14 meals (7 lunches and 7 dinners). For example, the child eats fish twice at school and once with his/her parents, the fish consumption frequency is 3.

|  |  |
| --- | --- |
| Food | Times a week |
| MEAT |  |
| FISH |  |
| EGG |  |
| LUNCH MEAT |  |
| CHEESE |  |
| PIZZA |  |