

MEDICAL HISTORY AND CONSULTATION QUESTIONNAIRE FOR CHILDREN

Dear Parents,

please take a few minutes to answer the following questions. Filling in this questionnaire is an important contribution so that we can judge the state of your child's health reliably. Thus, we'll be able to provide better consultation and select the right treatment for your child.

PERSONAL INFORMATION

Patient: Name, First Name _____

Patient: Date of Birth _____

Patient: Address _____

Main insured: Name, First Name _____

Main insured: Address (if different) _____

Phone _____

Mobile _____

E-mail _____

Health Insurance _____

OVERALL MEDICAL HISTORY

Does your child regularly take medication? Yes No

If so, which ones? _____

Does your child have an allergy passport? Yes No

Does your child have a tendency for allergic reactions against certain materials, medications, food? Yes No

Does your child have an allergy against penicillin, iodide or latex? Yes No

Does your child suffer from a cardiac illness? Yes No

If so, which one(s)? _____

Does/did your child have congenital or acquired heart defects? Yes No

Does/did your child have heart valve defects? Yes No

Does/did your child have endocarditis? Yes No

Does/did your child have heart operation(s)? Yes No

Does your child suffer from asthma or lung disease? Yes No

Does your child suffer from blood disorders or blood coagulation disorders?

Yes No

Does your child suffer from nerve disorders?

Yes No

Does your child suffer from epilepsy?

Yes No

Does your child suffer from infectious diseases?

Yes No

DENTAL MEDICAL HISTORY

When was your child's last dental visit? _____

Has your child ever had a bad experience during a dental visit?

Yes No

What is the reason for today's dental visit? _____

Does your child have a toothache?

Yes No

Has your child ever been treated with anaesthesia?

Yes No

Did your child ever experience problems after dental anaesthesia?

Yes No

If so, which ones? _____

Does your child have experiences with laughing gas?

Yes No

CONSULTATION

Would you like to receive more information about caries prophylaxis (prophylaxis, saliva diagnosis, fissure sealing, nutrition)?

Yes No

Would you like to receive more information about options for orthodontic adjustment of crooked teeth?

Yes No

Would you like to get specific advice about the future of your child's teeth?

Yes No

Was our practice recommended to you?

Yes No

If so, by whom? _____

Name and address of the pediatrician: _____

Thank you!

Once again, thank you very much for filling in this questionnaire.

If answering one or more questions was difficult or unclear, please tell us about it.

Date

Signature