Kinderzahnarztpraxis Dr. Bettina Brem

Lachende Kinder – lachende Zähne

Anamnesis of the Child

Name of the child	Date of birth

Please carefully read the questions concerning health and check the appropriate boxes:

Did you detect the following diseases/symptoms on your child? If so, which?

	yes	no
1. Cardiac conditions, defects or murmurs? Cardiac record card since: _____	☐	☐
2. Compounded respiration, asthma or other pulmonary diseases?	☐	☐
3. Liver or kidney diseases?	☐	☐
4. Infectious diseases (e.g. hepatitis, tuberculosis, HIV)? Please specify _____	☐	☐
5. Diabetes or metabolic diseases?	☐	☐
6. Bad blood coagulation or other hemic diseases?	☐	☐
7. Strong febrile seizures or other epileptic seizures?	☐	☐
8. Modified tonicity or spastic seizures?	☐	☐
9. Mental impairments or handicaps?	☐	☐
10. Hearing problems or deafness?	☐	☐
11. Speaking problems?	☐	☐
12. Other diseases? If so, which? _____	☐	☐
13. Is your child allergic? If so, to what?	☐	☐
14. Does your child regularly use medication? If so, which? _____	☐	☐
15. Has your child had a tetanus shot?	☐	☐
16. Peculiarities of the birth:	☐	☐
☐ Premature delivery? ☐ Caesarean section? ☐ Forceps delivery?		
17. Was your child treated as an inpatient in a hospital?	☐	☐
Why? _____		
18. Name of the pediatrician: _____		

Dental Anamnesis

	yes	no
1. Did your child see already see a dentist? If so, when and by whom was your child treated?	☐	☐
_____		
2. Did your child already have a negative experience with a dentist?	☐	☐
3. Did your child have an accident which injured the mouth or face?	☐	☐
4. Does your child suck on a pacifier or thumb?	☐	☐
5. Does your child have toothache?	☐	☐
6. What is the reason for today's visit? _____		

Nutrition habits

1. Did you nurse your child? If so, how long? _____		☐	☐
2. Did you or do you let your child drink from a bottle?		☐	☐
To what age? _____ At what time? ☐ In the morning ☐ In the evening ☐ At night			
What was / is in the bottle? _____			
3. What does your child mostly drink nowadays? _____			
4. Do you regularly give your child sweets?		☐	☐
5. Does your child use:	Fluoriding toothpaste	☐	☐
	Fluoriding table salt	☐	☐
	Fluorid tablets (Zymafluor)	☐	☐
6. How often do you brush your child's teeth? _____			

Anamnesis of the Parents

Mother

	yes	no
1. Are you allergic to anything? To what? _____	☐	☐
2. Are there pharmaceuticals that do not agree with you? W_____	☐	☐
3. Are you prone to caries?	☐	☐
4. Are you prone to dental calculus?	☐	☐
5. Are you afraid of visiting a dentist?	☐	☐

Father

	yes	no
1. Are you allergic to anything? To what? _____	☐	☐
2. Are there pharmaceuticals that do not agree with you? Which? _____	☐	☐
3. Are you prone to caries?	☐	☐
4. Are you prone to dental calculus?	☐	☐
5. Are you afraid of visiting a dentist?	☐	☐

I confirm having answered all questions regarding anamnesis to the best of my knowledge.

_____ _____

Date Signature legal guardian