



Anamnesis of the Child

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

3. Did your child have an accident which injured the mouth or face? yes no

4. Does your child suck on a pacifier or thumb? yes no

5. Does your child have toothache? yes no

6. What is the reason for today's visit? _____

Nutrition habits

1. Did you nurse your child? If so, how long? _____ yes no

2. Did you or do you let your child drink from a bottle? yes no

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? yes no

5. Does your child use: Fluoriding toothpaste yes no

Fluoriding table salt yes no

Fluorid tablets (Zymafluor) yes no

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? _____ yes no

2. Are there pharmaceuticals that do not agree with you? W _____ yes no

3. Are you prone to caries? yes no

4. Are you prone to dental calculus? yes no

5. Are you afraid of visiting a dentist? yes no

Father

yes no

1. Are you allergic to anything? To what? _____ yes no

2. Are there pharmaceuticals that do not agree with you? Which? _____ yes no

3. Are you prone to caries? yes no

4. Are you prone to dental calculus? yes no

5. Are you afraid of visiting a dentist? yes no

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

Date

Signature legal guardian