Praxis für Zahnheilkunde
Dagmar Kuroszczyk
Dr. med. dent. Anke Lott
Zahnärzte

Children and teenagers

Patient:

Family name _____ First name _____ Date of birth _____

Postcode _____ Town/city _____

Street/house no. _____ Telephone no. _____

Health insurer / cost carrier _____

Insured with:

Family name _____ First name _____ Date of birth _____

Postcode _____ Town/city _____

Street/house no. _____ Telephone no. _____

Legal guardian? ◯ Father ◯ Mother ◯ Other _____

Reason for today's dental appointment? _____

Has your child ever had a bad experience at the dentist due to: _____

_____

Previous dentist? _____

Describe your child's previous experience of dental treatment. _____

When was the last dental appointment? _____

Has your child ever experienced dental pain? ◯ yes ◯ no

Has your child ever suffered any injuries to the mouth or jaw area? ◯ yes ◯ no

Does your child suffer from any of the following

◯ Asthma ◯ Diabetes ◯ Seizures (e.g. epilepsy)
◯ Hearing disorder ◯ Spasticity ◯ Thyroid disorder
◯ Kidney disorder ◯ Lung disorders ◯ Blood disorder
◯ Tuberculosis ◯ Liver disorder / jaundice ◯ Rheumatism / rheumatic fever
◯ Nerve disorder ◯ Gastro-intestinal disease ◯ Immune deficiency (AIDS)
◯ Mental disability ◯ Delayed mental development ◯ Learning disability

Does your child suffer, or has your child ever suffered from a heart disorder? ◯ yes ◯ no

◯ Congenital or acquired heart disorder ◯ Heart surgery ◯ Other information: _____

Does your child suffer from any other illnesses/disorders? ◯ yes ◯ no

If so, please specify _____

Does your child suffer from any allergies? ◯ yes ◯ no

If so, please specify _____

Does your child take any medication? ◯ yes ◯ no

If so, please specify _____

Does your child breathe through his/her mouth? ◯ yes ◯ no

Parents' medical history:

Do you have any allergies that you are aware of? ◯ yes ◯ no

If so, please specify _____

Are you prone to any of the following?	Father:	Mother:
Cavities?	◯ yes ◯ no	◯ yes ◯ no
Tartar?	◯ yes ◯ no	◯ yes ◯ no
Bleeding gums?	◯ yes ◯ no	◯ yes ◯ no
Fear of the dentist?	◯ yes ◯ no	◯ yes ◯ no

Your child's eating habits:

Does your child have a sweet tooth? ◯ yes ◯ no

If so, how often does he/she eat sweets/candie? ◯ Seldom ◯ Once a day ◯ Several times a day

What does your child have for breakfast?

To drink: ◯ Tea / coffee with sugar ◯ Tea / coffee without sugar ◯ Milk ◯ Drinking chocolate
◯ Fruit juice ◯ Other _____

To eat: ◯ Bread ◯ Butter ◯ Jam or marmalade ◯ Chocolate spread ◯ Cheese ◯ Cold meat
◯ Muesli ◯ Cornflakes ◯ Fruit ◯ Sweets ◯ Other: _____

What does your child have for lunch? (Name a few everyday examples) _____

_____

What snacks does your child eat between meals? ◯ Cake ◯ Sweets ◯ Crisps, pretzel sticks ◯ Sandwiches ◯ Fruit

What does your child have for his/her evening meal? (Name a few everyday examples) _____

_____

What does your child drink during the day? ◯ Tap water / mineral water ◯ Sugared fizzy drinks ◯ Tea ◯ Milk
◯ Drinking chocolate ◯ Fruit juice ◯ Coca Cola ◯ Other: _____

Dental hygiene

Are the child's teeth brushed: ◯ By the child him/herself? ◯ With the help of a parent? ◯ By a parent?

When are the child's teeth brushed? ◯ Before breakfast ◯ After breakfast ◯ After lunch
◯ Immediately after the evening meal ◯ Before going to bed

What dental hygiene products are used? ◯ Manual toothbrush ◯ Electric toothbrush ◯ Oral water jet
◯ Dental floss ◯ Dental sticks ◯ Interdental brush

Toothpaste: Brand: _____ ◯ With fluoride ◯ Without fluoride

Extra fluoride:

Do you give or have you ever given your child "D-Fluoretten" tablets? ◯ yes ◯ no

Over what period of time? _____

Zymafluor? ◯ yes ◯ no

Does the child use fluoride gel (e.g. Elmex Gelee)? ◯ yes ◯ no When, how often? _____

Does the child use a fluoridated mouthwash? When, how often? _____

Fluoridation by the dentist? ◯ yes ◯ no

Do you use fluoridated salt at home? ◯ yes ◯ no

Drinking behaviour in infants and preschool children

How long was your child breastfed? _____

How long did your child drink from a bottle? _____

Does your child still drink from a feeding bottle? ◯ yes ◯ no

◯ Water ◯ Fizzy drinks ◯ Fruit juice ◯ Sweetened tea ◯ Unsweetened tea ◯ Sweetened fruit tea
◯ Unsweetened fruit tea

Does your child drink out of a cup? ◯ yes ◯ no

◯ Water ◯ Fizzy drinks ◯ Fruit juice ◯ Sweetened tea ◯ Unsweetened tea ◯ Sweetened fruit tea
◯ Unsweetened fruit tea ◯ Milk ◯ Drinking chocolate

print

Date _____ Signature _____

Thank you for your cooperation! Please notify us immediately of any changes to the above-stated information.