KiDSMiLE

Children's Health Questionnaire (Anamnestic questionnaire)

Instruction and written informed consent of the patient to § 6 of Act no. 576/2004 Coll.

Name and surname:	**Name and surname (parent):**
Date of birth:	**Tel. Number of parents:**
Birth number:	**Address:**
Insurance company:	**e-mail:**
Current weight of the child:	**Reason for visiting:**
How did you hear about our clinic?	

Has your child been ill in the past, or being treated for any of these conditions described below?			
Any problems with breathing, sinuses?	Yes	No	I don't know
High/low blood pressure?	Yes	No	I don't know
Congenital heart effects?	Yes	No	I don't know
Other heart defects?	Yes	No	I don't know
Vascular disease?	Yes	No	I don't know
Rheumatic fever?	Yes	No	I don't know
Illness of thyroid gland?	Yes	No	I don't know
Blood disease?	Yes	No	I don't know
Does your child bruise easily?	Yes	No	I don't know
Long bleeding after treatment?	Yes	No	I don't know
Icterus?	Yes	No	I don't know
If so, what kind?	A	B	C
Kidney disease?	Yes	No	I don't know
Burning when urinating?	Yes	No	I don't know
Urinary tract inflammation?	Yes	No	I don't know
Diabetes?	Yes	No	I don't know
Epileptic seizures?	Yes	No	I don't know
Psychological diagnose (autism, hyperactivity etc.)?	Yes	No	I don't know
Oncological disease? Cancer?	Yes	No	I don't know
HIV positive?	Yes	No	I don't know

Is your child currently taking any medications?	Yes	No	I don't know

If yes, please indicate which and for which disease: _____

Has your child ever been hospitalized?	Yes	No	I don't know
Has your child been operated?	Yes	No	I don't know

Allergies or medicine/drugs reactions

Is your child allergic to penicillin, acylpyrine or analgesics?	Yes	No	I don't know

Is your child allergic to other medicines/drugs?	Yes	No	I don't know

If yes, please indicate for which medicines/drugs: _____

Does your child have an allergy to dust, pollen, material, food?	Yes	No	I don't know

If yes, please specify to which: _____

Has your child ever had a reaction to sedatives or local anaesthesia?	Yes	No	I don't know

If yes, please specify _____

Does your child suffer of any of the diseases not listed above?	Yes	No	I don't know

If yes, please specify _____

Dental history

Has your child ever been to a dentist for treatment?	Yes	No	I don't know
Date of last treatment?			
Is your child nervous of doctor?	Yes	No	I don't know

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Thumb sucking, pacifier?	Yes	No	I don't know
Nail biting?	Yes	No	I don't know
Lip biting?	Yes	No	I don't know
Aphthae?	Yes	No	I don't know
Problems with mouth opening?	Yes	No	I don't know
Jaw cracking?	Yes	No	I don't know
Clashing of gears? Odontaspis's?	Yes	No	I don't know
Wearing braces?	Yes	No	I don't know
Tooth sensitivity?	Yes	No	I don't know

Dental hygiene

What kind of toothbrush do your child use?	Classic	Electric	Sonic
If classic what kind?	Soft	Middle	Hard
Does your child use interdental brush, dental floss?	Yes	No	I don't know
How many times a day does your child brush?			
Do you clean your child's teeth?	Yes	No	

Others

Were any problems during pregnancy (infections, risk pregnancy etc.)	Yes	No	I don't know
Any complications during birth (premature, low Apgar)?	Yes	No	I don't know

If yes, please specify: _____

How long was your child breast feeded?			
When did he/she have first tooth?			
Were any problems during teeth grow?	Yes	No	I don't know

Had your child a tooth injury?	Yes	No	I don't know

If yes, please specify: _____

Do you have any teeth abnormality in your family (hypodontia or hyperodontia)?	Yes	No	I don't know

If yes, please specify: _____

Parent's signature, date: _____

The patient confirms with his/her signature, the correctness of data filled in the anamnestic questionnaire and agrees with processing of it. This anamnestic form is for the purpose of the professional consultation you requested at the dentist office KIDSMILE s.r.o. and includes the processing of your personal data, including clinical and non-clinical information, related to this professional consultation. The information you provide will become part of the medical documentation and may later become the basis of creating a treatment plan or making your individual health card.

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