ADDITIONAL MEDICAL HISTORY QUESTIONNAIRE – KIDS

Name of patient/child ______________________________

Have the following disorders/symptoms occurred with your child:

Difficulty with breathing	☐ Yes	☐ No
Mental disability or mental retardation	☐ Yes	☐ No
Deafness or hearing problem	☐ Yes	☐ No
Blindness or impaired vision	☐ Yes	☐ No
Speech problems or learning disability	☐ Yes	☐ No
Are commonly recommended vaccinations missing?	☐ Yes	☐ No
If yes, which?	______________________	

Your child's dental history

Has your child ever been to a dentist?	☐ Yes	☐ No	
Did or does your child have toothaches?	☐ Yes	☐ No	
Did your child ever have a negative experience with a dentist?	☐ Yes	☐ No	
Does your child use a dummy (pacifier) or suck his/her thumb?	☐ Yes	☐ No	
Do the gums bleed when brushing the teeth?	☐ Yes	☐ No	
Has your child ever had an accident in the orofacial region?	☐ Yes	☐ No	
Have operations already been performed in the maxillofacial region?	☐ Yes	☐ No	
If yes, which?	______________________		
Has an orthodontics appointment/treatment already occurred?	☐ Yes	☐ No	
If so, when and where?	______________________		
Do you give your child fluoride preparations?	☐ Yes	☐ No	
If yes, which:	☐ Toothpaste	☐ Salt fluoride	☐ Tablets

Dietary habits

Was your child fed with a feeding bottle?	☐ Yes	☐ No
If yes, up to which age?	______________________	
If yes, at what meals?	______________________	
If yes, exactly what food was/is fed?	______________________	
Is your child a good eater?	☐ Yes	☐ No
Does your child often eat sweet things?	☐ Yes	☐ No
Does your child often drink sweet beverages (juices/soft drinks/iced tea)?	☐ Yes	☐ No

Berlin, ____

Date/signature of legal guardian
(With my signature I confirm the completeness and correctness of my details mentioned above.)