

# Anamnesis questionnaire children

*(please write distinctly and in capital letters)*

Dr. Maaß & Held

Dr's office of modern  
orthodontics

female  male

## patient

surname: ..... prename: ..... date of birth: .....

street: ..... postcode/city: .....

tel./cell phone nr.: ..... email: .....

## father

surname: ..... prename: .....

street: ..... postcode/city: .....

tel./cell phone nr.: ..... email: .....

## mother

surname: ..... prename: .....

street: ..... postcode/city: .....

tel./cell phone nr.: ..... email: .....

Your child is insured with?  Father  mother  itself  pensioner

## name of your treating dentist:

legal health insurance company name: .....

covered private insurance: .....

allowance or subsidy office: .....

Are there brothers and sisters treated orthodontically?  yes  no

Does your child have an orthodontic treatment now or in former times?  yes  no

Orthodontist name: .....  when .....

## Cardio-vascular diseases

high blood pressure  yes  no | low blood pressure  yes  no

heart surgeries  yes  no | disturbance in coagulation of the blood  yes  no

endocarditis (bacterial endocardium disease)  yes  no | cardiac valvular effect or replacement  yes  no

actual medication for heart and blood pressure: .....

Please notice the backside of the questionnaire (S.2)

**juvenile idiopathic arthritis (JIA) = rheumatic children disease:**  yes  no

**medication for rheumatism diseases:**

**Infectious diseases**

HIV infection /AIDS  yes  no

hepatitis (if so, which kind of A B C D)  yes  no

tuberculosis (TB)  yes  no

herpes positive  yes  no

other infectious diseases, if so, which one? )  yes  no

medications for diseases above:

**Cancer/tumors** cancer medications:  yes  no

**Other diseases**

neurological diseases  yes  no

epilepsy  yes  no

lung/pulmonary diseases (dyspnea/asthma/cystic fibrosis mucoviscidosis)  yes  no

diabetes  yes  no

thyroid diseases  yes  no

gastric-, intestinal,- kidney diseases  yes  no

immune diseases  yes  no

Other not mentioned diseases or medications?  yes  no

which?

**allergies/incompatibilities**

allergy ID issued in the year:

latex  yes  no

nickel or other metals: (if so, which )  yes  no

anesthetics: (if so, which )  yes  no

analgesics: (if so, which )  yes  no

antibiotics: (if so, which )  yes  no

**Other orthodontically relevant questions**

Required trauma of teeth: (if so, which and when? )  yes  no

Did your dentist take x-rays of your child in the last 2 years?  yes  no

Did your child have surgery in the ear, nose and throat region?  
(adenoids, tonsils, sinuses, nasal septum)  yes  no

Does your child sleep open - mouthed?  yes  no

Did your child suck or is he/she still sucking the thumb or pacifier? (if yes, how long?)  yes  no

Are there malpositions of the teeth or jaws or special diseases in your family?  yes  no

Does your child have a speech defect?  yes  no

(For girls only) Is your daughter pregnant at the moment? (if so, in which month of?)  yes  no

**It is very important that we have enough time for the orthodontic treatment of your child!**

**Of course, we depend on the timetable of your child, but in a few exceptional cases we have to renounce it, to guarantee the medical-orthodontic relevant execution. If requested, we will deliver an attestation for the school. Please give us a confirmation, that you agree with this arrangement during the hole treatment.  Yes, I agree**

**I declare that I degree, that the medical confidentiality can't be observed permanently because of the spatial Dr's office situation.  yes**

City, date:

signature: