Dental Fantasy

A child's health questionnaire

Dear parents!

Please, take some time to fill in this questionnaire. The information you provide is essential for an adequate and safe dental treatment of your child and for the good prognosis.

The child's Last name, First name, and Patronymic: ____

____

The child's date of birth ______________________________________

1. Does your child have or did he/she have any of these diseases/conditions:

- ☐ Mineral metabolism disorders (including rickets)
- ☐ Gastrointestinal tract disorders
- ☐ Heart disorders
- ☐ Kidney disorders
- ☐ Endocrine system disorders
- ☐ Respiratory tract disorders
- ☐ Nervous system disorders
- ☐ Blood disorders

2. Which traumas/operations/hospitalizations did your child have? ________________________________

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3. Is your child currently taking any medications?

If yes, which ones: ____

____

4. Have your child had any allergic reactions?

If yes:

a. What causes the allergy ____

b. How does it appear (redness, rash, itch, edema, watering eyes, anaphylactic shock, etc.) or

____

c. Date and time of the last allergic reaction:____

5. I would like to add the following about my child's health:

____

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____

E-mail: ____

Mobile phone: ____

Date _____________ Signature______________ / ____________________/

Patient record number (filled in by the clinic's staff) ______________________________