**Health Questionnaire - kids**

Name: Date of Birth: male *I* female

**why is the health questionnaire important for your dentist and dental hygienist?**

* **complaints in the mouth can be caused by disease or use of medication.**
* **When you are sick, have an illness or if you use medication it could be a limitation for the dental treatment or could be a reason to take some precautionary measures. It is very important that your dentist takes note.**

**Please inform your dentist in case anything might change in your health or your use of medicine. Your data is covered by medical professional secrecy and is therefore treated confidentially.**

**Please bring a recent medication overview during every visit to your dentist. You can request a recent overview from your pharmacist.**

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| --- | --- | --- | --- |
| Has anything changed in your kids health in recent months? | No | Yes | If so, what? |
| Is your child under treatment of any specialist? | No | Yes | If so, what? |
| Is your child allergic to something? | No | Yes | If yes, for what? |
| Is your child short of breath when he/she lies flat in bed? | No | Yes |  |
| Does your child have a heart valve defect or an artificial heart valve? | No | Yes |
| Has your child ever fainted with dental or medical treatment? | No | Yes |
| Does your child have epilepsy, falling illness? | No | Yes |
| Does your child suffer from lung complaints such as asthma, bronchitis or chronic cough? | No | Yes |
| Does your child have diabetes? | No | Yes | Does your child use insuline? **Yes / No** |
| Do you have anemia? | No | Yes |
| Have you had hepatitis or other liver disease? | No | Yes |
| Does your child has a kidney disease? | No | Yes |
| Does your child has any problems with food or stomach-bowels problems? | No | Yes |
| Is your child hyperactive or does your child has any other behavior problems? | No | Yes | What? |
| Is your child going to special education or to a medical childcare? | No | Yes |  |
| Does your child has any other disease we did not ask about? | No | Yes | What? |
| Does your child use medicines? | No | Yes | What? |
| **Date: Signature:** |