UNIVERSITÄTSZAHNKLINIK
MEDIZINISCHE UNIVERSITÄT WIEN

Medical history form for children

Patient label

Surname: _____

First name: _____

Nickname: _____

Date of birth: _____

Gender: ☐ m ☐ w ☐ diverse

Social insurance: _____

Address: _____

Favourite activity: _____

Parent/guardian: ☐ Mother ☐ Father

☐ MA11 ☐ Other: _____

Parent/guardian 1 (first name and surname): _____ Date of birth: _____ Title: _____

Parent/guardian 2 (first name and surname): _____ Date of birth: _____ Title: _____

Other (first name and surname): _____ Date of birth: _____ Title: _____

Telephone number of parent/guardian(s): _____ Email: _____

Co-insured: ☐ Yes ☐ No With whom? _____

Name and age of siblings:

_____

Supplementary dental insurance: ☐ Yes ☐ No Insurer: _____ Policy no.: _____

General dentist / Address: _____

General practitioner / Address: _____

How did you hear about us?	☐ Referral	☐ General dentist	☐ Paediatrician
	☐ Recommendation	☐ Self-referred	
	☐ Other: _____		
Reason for today's dentist appointment?	☐ Pain	☐ Check-up	☐ Accident
	☐ Caries	Other: _____	

Has your child ever been to the dentist? ☐ Yes ☐ No		
If so, when was your child's last dentist appointment? _____		
If so, what experience did your child have? ☐ Good ☐ Average ☐ Poor		
Comment: _____		
Has your child ever had an accident involving their mouth/jaw area?	☐ Yes	☐ No
Does your child breathe through their mouth?	☐ Yes	☐ No
Has your child ever received speech and language therapy?	☐ Yes	☐ No
Is your child currently under regular medical care?	☐ Yes	☐ No
Does your child take medication regularly?	☐ Yes	☐ No
If so, which medicines and at what dosage? _____		
Were the pregnancy and birth normal?	☐ Yes	☐ No
If not, why? _____		
Child's birth weight? _____		
Has your child previously had any feverish illnesses?	☐ Yes	☐ No
If so, at what age? _____		
Has your child ever had surgery?	☐ Yes	☐ No
Has your child ever been in any serious accidents?	☐ Yes	☐ No
Has your child ever been hospitalised?	☐ Yes	☐ No

Childhood illnesses ☐ Measles ☐ Mumps ☐ Rubella ☐ Diphtheria

Is your child vaccinated? ☐ Yes ☐ No

If so, which? ☐ Measles ☐ Mumps ☐ Rubella ☐ Diphtheria ☐ Tetanus

Cardiovascular diseases

☐ Heart disease

☐ High blood pressure

☐ Does your child have a pacemaker?

☐ Heart valve replacement

☐ Stroke

☐ Other cardiovascular diseases?

If so, which medications / injections? _____

Blood disorders

☐ Blood clotting disorders

☐ Anaemia

☐ Anticoagulant medication

☐ Thrombosis

☐ Other blood disorders?

If so, which medications / injections? _____

Allergies

☐ Dental materials

☐ Penicillin

☐ Local anaesthetics

☐ Latex allergy

☐ Does your child have an allergy card?

☐ Other allergies?

If so, which medications / injections? _____

Infectious diseases

☐ Tuberculosis

☐ Hepatitis A / B / C

☐ AIDS / HIV

☐ Other infectious diseases?

If so, which medications / injections? _____

_____

Other conditions

☐ Asthma / lung diseases

☐ Diabetes (sugar diabetes)

☐ Epilepsy

☐ Glaucoma

☐ Liver diseases

☐ Thyroid diseases

☐ Kidney disease

☐ Gastrointestinal diseases

☐ Hearing impairments

☐ Spasticity

☐ Developmental delay

☐ Intellectual disability

☐ Learning disability

☐ ADHD

☐ Syndrome

☐ Cancer / tumour disease

☐ Other conditions?

If so, which medications / injections? _____

_____

Parents' medical history

Do you have any known allergies? ☐ Yes ☐ No

If so, which medications / injections? ☐ Mother: _____

☐ Father: _____

		Mother		Father	
Do you tend to have:	Caries (tooth decay)	☐ Yes	☐ No	☐ Yes	☐ No
	Tartar	☐ Yes	☐ No	☐ Yes	☐ No
	Bleeding gums	☐ Yes	☐ No	☐ Yes	☐ No
	Dental anxiety	☐ Yes	☐ No	☐ Yes	☐ No

I acknowledge that I must notify you of any changes to my child's personal or medical data as soon as possible in order to ensure that the best possible treatment and care can be provided.

CONSENT AND INFORMATION

Please read the following paragraphs carefully and confirm your consent by signing below.

- The University Clinic of Dentistry Vienna is a teaching institution. I acknowledge that treatment may also be provided by students under medical supervision.

- I acknowledge that the organisation of the clinic and teaching means that the course of treatment is divided into many stages, each of which must be monitored by dentists. The entire process requires a considerable amount of time, especially if preliminary treatment or cooperation between different clinical departments is necessary.

- Treatment at the University Clinic of Dentistry Vienna follows a holistic concept for the rehabilitation of the masticatory system, so the treatment period may extend over months or even years.

- I acknowledge that, for the purpose of documenting the course of treatment, imaging examinations as well as photographic or video recordings may be made during treatment and follow-up care.

- Medical research: The University Clinic of Dentistry Vienna is a legally recognised research institution. We use your patient data (including diagnostic imaging, photographic documentations and video recordings) in pseudonymised form for research projects. Names or other direct identifying characteristics will not be published; any analyses are presented in summarised form and do not allow any conclusions to be drawn about you personally. This is done on the basis of statutory provisions (Austrian Research Organisation Act – FOG) and in compliance with the highest data protection standards. Your consent is not required for this; however, you have the right to obtain information. In view of this statutory authorisation, there is no possibility to object. Detailed information about your rights, the processing of your data and the research purposes can be found in our separate “data protection declaration – research” [https://www.unizahnklinik-wien.at/datenschutz/].

Vienna, _____

_____

Signature of legal representative: