Praxis für Kinder- & Jugendmedizin

Dr. med. Sonja Burzin
Fachärztin für Kinder- und Jugendmedizin

Welcome!

We are happy you commit the health of your child to us.
To provide a treatment in the best way possible, we ask you to fill in this questionnaire completely.
If you have any questions, we are happy to help you.
Please inform us about any changes (e.g. address, phone number or insurance contract).

Name of the patient:	Prename:	Date of birth:
Country of origin:	O Germany	O Other:
First language:	O German	O Other:
Postcode:	Place of domicile:	Street:
Home telephone number:	Mobile telephone number:	E-mail:
Insurance:	O Statutory health insurance	O Private health insurance
Name of the main person insured:	Prename:	Date of birth:
On whose recommendation do you come? / How did you find us?		
Do you have a special request for your treatment? O Yes O No If so which? -		
I hereby confirm the correctness of my personal data as well as my agreement with this information. If you don't show up to your appointment, please cancel your appointment 24 hours in advance otherwise we have to invoice 50 Euro.		
Date:	Signature:	

Please turn over the page

Background questions about the past history and the family situation:

Are there any illnesses or vulnerabilities? no 0 yes 0

0 heart defect	0 urinary tract infection
0 high blood pressure	0 circulatory weakness
0 fainting spells / blackouts	0 seizures
0 overweight	0 kidney disease
0 hyperactivity	0 chronic infections (Hepatitis B, HIV)

Do you run a caries prophylaxis with fluoride tablets? no 0 yes 0
Do you use fluoride toothpaste? no 0 yes 0

Does your child regularly take medicines? no 0 yes 0
If so, which?
-
-

Was a hospital visit necessary yet? no 0 yes 0
If so, why?
-
-

Any operations (When, which, complications)? no 0 yes 0
-
-

Does your child have any allergies, illnesses like asthma, neurodermatitis or allergic rhinitis? (What type?) no 0 yes 0
-
-

Do your relatives have any allergies, illnesses like asthma, neurodermatitis or allergic rhinitis? (What type?) no 0 yes 0
-

Do you smoke in your household? no 0 yes 0

Do you have any pets? no 0 yes 0
If yes, which?

Are there any environmentally or living problems? no 0 yes 0
If yes, which:

Did your child have a hip treatment during his first year? no 0 yes 0
Do/ Did the parents or siblings have any hip complaint? no 0 yes 0
Do the parents or siblings have any debility of sight or hearing loss of? no 0 yes 0
Do the parents or siblings have any spasm or epilepsy? no 0 yes 0
Do the parents or siblings have any mental health issues? no 0 yes 0
If yes, which?

Do the parents or siblings have any bleeding disorder? no 0 yes 0
Do the parents or siblings have any predisposition of thrombosis? no 0 yes 0
Did any of your relatives have a heart attack, a sudden cardiac death or a stoke before the age of 45? no 0 yes 0
Do any of your close relatives have coeliac disease (non-tropical sprue)? no 0 yes 0
Do any of your close relatives have other chronical or life-threatening diseases? no 0 yes 0
If yes, which?
Do you want to add something you haven't been asked about yet? no 0 yes 0

Thanks a lot for taking the time, Yours Dr. Sonja Burzin and team