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| C:\Users\Praxis\Desktop\Logo_Dr_Kroemer 02 09 09.jpg  **Anamnesebogen** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Vorname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Straße, Nr.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PLZ, Ort: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Geburtsdatum: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | **E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Telefon privat: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | **Telefon tagsüber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Versicherter / Zahlungspflichtiger(wenn Sie nicht selbst Krankenversicherungsmitglied sind)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name: ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Vorname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Straße, Nr.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PLZ; Ort: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Geburtsdatum: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | **Telefon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Beruf des Zahlungspflichtigen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name Krankenkasse oder Versicherung: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **O** | **Ich bin nicht versichert** | | | | **O** | | | | | | **Ich bin mit einem Basistarif versichert (betrifft nur Privatversicherte)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Quellbild anzeigen  **Das würde uns noch interessieren** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Normale Entwicklung des Kindes** | | | | | | | | | | | | **O** | | | | | | | Ja | **O** | | Nein | | |
| **Anmerkungen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Ist Ihr Kind z. Zt. in ärztlicher Behandlung?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Wenn ja, bei wem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Ist das der erste Besuch beim Zahnarzt?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **O** | **Ja** | | **O** | **Nein** | |  | | | | | | |
| **Hat Ihr Kind Angst?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **O** | J**a** | | **O** | **Nein** | |  | | | | | | |
| **Wie wollen Sie an ihren Vorsorgetermin erinnert werden?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **O** | | **telefonisch** | | | | | | | **O** | | | | | | | **schriftlich** | | | | | | | | | | | | | **O** | | | | | | | **Email** | | | | | | | | | | | | | | |
| **Hat oder hatte Ihr Kind folgende Krankheiten?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **O** | | **Asthma (schwere Atemnot)** | | | | | | | **O** | | | | | | | **Herzfehler / -krankheit** | | | | | | | | | | **O** | | | | | | **Nein** | | | | | | | | | | | | | |
| **O** | | **Zuckerkrankheit** | | | | | | | **O** | | | | | | | **Anfallsleiden (Epilepsie)** | | | | | | | | | |  | | | | | |
| **O** | | **Nierenerkrankungen** | | | | | | | **O** | | | | | | | **Hepatitis A/B/C (Gelbsucht** | | | | | | | | | |
| **O** | | **Blutgerinnungsstörungen** | | | | | | |  | | | | | | |  | | | | | | | |  | | | | | | |  | | | | | | | | | | | | | | | |
| **ggf. seit wann? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Sonstige Erkrankungen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Nimmt Ihr Kind regelmäßig Medikamente?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **O** | | **Ja** | | | | | | | **O** | | | | | | | **Nein** | | | | |
| **Wenn ja, welche? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Hat Ihr Kind allergische Reaktionen / Unverträglichkeiten auf Medikamente bzw. Materialien** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **O** | | **Ja** | | | | | | **O** | | | | | | | **Nein** | | | | | | | | | | | | | | | | | | | |
| **Wenn ja, welche? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Putzt Ihr Kind seine Zähne allein?** | | | | | | | **O** | | | | | | | **Ja** | | | | | | | | | | | | | **O** | | | | | | **Nein** | | | | | | |  | | | | | | | | | |
| **O** | | **Handzahnbürste** | | | | | | **O** | | | | | | | **elektrische Bürste** | | | | | | | | **Wie oft täglich? \_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | |
| **Ernährung / Essgewohnheiten** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **O** | | **Überwiegend süß** | | | | | | **O** | | | | | | | **Überwiegend deftig** | | | | | | | | | | | | | **O** | | | | | | **gemischt** | | | | | | | | | | | | | |
| **O** | | **Obst / Gemüse** | | | | | | **O** | | | | | | | **Fast Food** | | | | | | | | | | | | |
| **O** | | **Isst unkontrolliert** | | | | | | **O** | | | | | | | **Isst wenig** | | | | | | | | | | | | | **O** | | | | | | **Isst viel** | | | | | | | | | | | | | |
| **Lieblingsessen:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **O** | | **Fruchtsäfte** | | | | | | **O** | | | | | | | **Limonaden** | | | | | | | | | | | | |
| **O** | | **Mineralwasser** | | | | | | **O** | | | | | | | **Tee ungesüßt** | | | | | | | | | | | | | **O** | | | | | | **Tee gesüßt** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Welche Lutschgewohnheiten hat Ihr Kind?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **O** | | **Daumen, Finger** | | | | | | **O** | | | | | | | **Schnuller** | | | | | | | | | | | | | | | | | | | | | | |
| **O** | | **Trinkfläschchen** | | | | | | **O** | | | | | | | **Sonstiges (z.B.: Beißring)** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Ist Ihr Kind in KFO- Behandlung?** | | | | | | | **O** | | | | | | | | | | **Ja** | | | | | | | | | | | | | **O** | | | | | | | **Nein** | | | |
| Wenn ja, seit wann? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| War ein Elternteil in KFO-Behandlung? | | | | | | | | | | **O** | | | | | | | **Ja** | | | | | | | | | | | | | **O** | | | | | | | **Nein** | | | |
| **…und zu guter Letzt !!!!** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Bitte teilen Sie uns Änderungen zum Gesundheitszustand Ihres Kindes mit, damit wir diese berücksichtigen können.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Datum / Unterschrift des Patienten oder Erziehungsberechtigten** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |