Medical history form

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Welcome!

Dear patient,
Before we can discuss your dental care wishes, we need some information about your general state of health in addition to your personal details. That's because even general illnesses can affect dental treatment. As a result, we ask that you fill out this questionnaire. It will be added to your personal data. All information is, of course, subject to doctor-patient confidentiality in our practice. **Information marked with (*) is not mandatory.**

PERSONAL

Surname / forename _____ Date of birth _____

Street / House no. _____ Post code / City _____

Tel. (private) _____ Tel. (mobile)* _____

Email* _____ Occupation* _____

Health insurance company _____ Level of care _____

Are you privately insured? ○ yes ○ no **Base rate?** ○ yes ○ no **Additional insurance?** ○ yes ○ no

If you are not the health insurance policy holder, who is the insured person?

Surname / forename _____ Date of birth _____

Are you eligible to receive benefits? ○ yes ○ no

Who is your GP?

Surname / forename _____ City _____

Tel. _____

About us*

How did you hear about us?

○ Recommended by a friend ○ Phone book / business directory ○ Online via _____

○ Referred by _____ ○ Other _____

If we were recommended to you, did you look at our website beforehand? ○ yes ○ no

Would you like to receive a reminder from us about your semi-annual check-up? ○ yes ○ no

If yes, how? ○ by phone ○ by mail ○ by email ○ by SMS

Information about the organisation
Premium quality is only possible without time pressure. We therefore ask that you cancel any appointment you cannot make at least 48 hours in advance so that we can give it to another patient. In the event of repeated appointment cancellations at short notice, we reserve the right to charge you for the length of time your appointment should have been.

PLEASE TURN OVER

Why are you visiting us? Do you want a...

○ routine check-up ○ new denture
○ consultation ○ "second opinion"
○ pain treatment ○ other reason:

Do you have acute pain? ○ yes ○ no

If yes, how does it manifest?

○ persistent pain
○ teeth react to sweet / sour
○ some teeth are temperature-sensitive
○ teeth hurt when under strain / chewing
○ teeth hurt even without strain
○ gum pain or inflammation
○ jaw pain / temporomandibular joint pain

Do you suffer / have you suffered from...

heart/circulatory disease ○ yes ○ no
liver disease ○ yes ○ no
kidney disease ○ yes ○ no
thyroid disease ○ yes ○ no
lung disease (asthma, COPD, etc.) ○ yes ○ no
gastrointestinal tract disease ○ yes ○ no
joint disease (rheumatism) ○ yes ○ no
tinnitus ○ yes ○ no
spinal disease ○ yes ○ no

Do you have or have you had...

high or low blood pressure ○ yes ○ no
If yes, which values? _____
diabetes ○ yes ○ no
osteoporosis ○ yes ○ no
bleeding gums ○ yes ○ no
epilepsy ○ yes ○ no
glaucoma or cataracts ○ yes ○ no
tuberculosis ○ yes ○ no
HIV (Aids) ○ yes ○ no
bleeding disorders ○ yes ○ no
hepatitis ○ yes ○ no
If yes, which type? _____
allergies ○ yes ○ no
If yes, to what? _____
Artificial joints? ○ yes ○ no
Other infections / diseases:

About your heart – do you have or have you had...

○ heart valve inflammation ○ angina pectoris
○ a pacemaker
If yes, when? _____
○ a heart attack, and if so when? _____

Medication – are you taking...

○ heart medication ○ cortisone (corticosteroids)
○ painkillers ○ antidepressants
○ blood-thinning medication, e.g. Marcumar, ASS?
○ injections / infusions / bisphosphonates
○ other medication/medication regime if applicable

Have you ever had intolerances to medication or injections?

○ yes ○ no
If so, to what? _____

For our female patients

Are you pregnant? ○ yes ○ no ○ unsure
If yes, which week are you in? _____

To protect the mother, we ask that you let us know immediately if you become pregnant during the treatment period!

Finally

Do you grate your teeth? ○ yes ○ no
FDo you feel under psychological strain? ○ yes ○ no
Do you smoke? ○ yes ○ no
Do you have a metallic taste? ○ yes ○ no
Have you noticed noises in your temporomandibular joint (e.g. when yawning or chewing)? ○ yes ○ no
Do you suffer from...
bad breath? ○ yes ○ no
receding gums? ○ yes ○ no
headaches or neck pain? ○ yes ○ no

Are you happy with the colour and shape of your teeth (in other words - your smile)? ○ yes ○ no

Questions / comments _____

Date, signature