

### Medical history

General diseases can also have an impact on dental treatment. Therefore, the law obliges us to ask for the information contained in this questionnaire. Please note that this information is subject to medical confidentiality. They serve exclusively to adapt our treatment to your state of health.

**Should there be any changes to your state of health or the medication you are taking at a later point in time, we ask you that you inform us of this immediately.**

Your details may be stored electronically by us, but are subject to the strict provisions of data protection..

**patient:**

\_\_\_\_\_  
surname first name date of birth

**insured person:**

\_\_\_\_\_  
surname first name date of birth

**address:**

\_\_\_\_\_  
post code residence street

\_\_\_\_\_  
phone number mobil number country

**Health insurance:** \_\_\_\_\_  State health insurance  
 private

**Employer:** \_\_\_\_\_

\_\_\_\_\_  
phone number work profession

**Are you interested in the following modern treatment methods?**

yes	no
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Treatment with dental laser  
 High quality ceramic fillings or ceramic composite  
 Professional dental cleaning  
 Denture cleaning


**Do you take any medication?**

\_\_\_\_\_  
drug: against: \_\_\_\_\_

\_\_\_\_\_  
drug: against: \_\_\_\_\_

\_\_\_\_\_  
drug: against: \_\_\_\_\_

		Yes	No
<b>Cardiovascular diseases</b>	cardiac pacemaker		
	irregular heartbeat		
	synthetic cardiac valve		
	endocarditis		
	congenital heart disease		
	high blood pressure		
	angina Pectoris		
	heart attack (-when?.....)		
<b>Metabolic diseases</b>	diabetes		
	disease of thyroid gland		
<b>Diseases of the CNS</b>	epilepsy		
<b>Blood diseases</b>	increased bleeding tendency		
	ingestion of anticoagulant medication		
	which ?.....		
	other blood disease :.....		
<b>Allergies</b>	allergic to penicillin		
	asthma		
	other allergies.....		
<b>Infectious diseases</b>	hepatitis ( A , B oder C ? )..... when ?.....		
	tuberculosis		
	HIV / AIDS		
	other (which?) .....		
<b>Diseases of Immune system</b>	If so, which? .....		
	.....		
<b>Other diseases</b>	If so, which? .....		
	.....		
<b>Ar you pregnant?</b>	Which month? .....		
<b>Do you smoke?</b>			
<b>Do you have any supplementary insurance?</b>			
<b>Do you want us to remind you of your next appointment (recall) ?</b>			

At this point, we would also like to point out that the local anesthesia ("injection") administered as part of a dental treatment can limit your ability to drive! (Please also note the enclosed information sheet on local anesthesia).

\_\_\_\_\_ date

\_\_\_\_\_ patient signature