BERUFSAUSÜBUNGSGEMEINSCHAFT
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Medical History Questionnaire

Please answer the following questions about your state of health as precisely as possible! The information is subject to medical confidentiality and the provisions of data protection and will be treated with the utmost confidentiality.

Personal Information

Name, First Name | Date of Birth | Place of birth

Street | ZIP/ City

Telephone number | Telephone number employer | Mobile Tel

Email | Profession

Would you like to receive an appointment reminder? ◯ SMS ◯ Email

Insurance

Insurance

◯ State health insurance ◯ Private Health Insurance ◯ Additional Teeth

If the patient and the member of the insurance are not identical, please complete the data of the policyholder

Name, First Name | Date of Birth | Place of birth

Street | ZIP/ City

How did you find out about us?

◯ Personal recommendation ◯ While passing ◯ Advert

◯ Referring doctor: ◯ Internet: ◯ Others:

please go to next site ...

General health situation

	yes	no
High Blood Pressure	◯	◯
Low Blood Pressure	◯	◯
Bleeding disorder	◯	◯
Stroke	◯	◯
Diabetic	◯	◯
Osteoporosis	◯	◯
Malignant tumor disease	◯	◯
Heart diseases if so please define:	◯	◯

_____

_____

Thyroid disease	◯	◯
Rheumatism	◯	◯
Allergies please define:	◯	◯

_____

_____

Other diseases please define:	◯	◯

_____

_____

	yes	no
Infectious diseases		
HIV	◯	◯
Hepatitis	◯	◯
Tuberculosis	◯	◯

Other: _____

Do you take medication regularly? ◯ ◯

please define:

◯ Heart medication: _____

◯ Cortisone: _____

◯ Painkiller: _____

◯ Antidepressants: _____

◯ Blood Thinner
please define:

_____

◯ Bisphosphonates: _____

◯ Other: _____

Are you smoking?	◯	◯
Are you pregnant?	◯	◯

If so, which week: _____

Oral health situation

What is your reason for coming to our practice?

◯ Preventive medical check-up ◯ Implants ◯ Pain treatment

◯ New dentures ◯ Referral dentist ◯ Consultation

◯ Others, please define: _____

	yes	no
Are you satisfied with the position, shape and color of your teeth?	◯	◯
Do you grind or clench your teeth?	◯	◯
Do you have gum problems?	◯	◯
Do you suffer from bad breath and bad taste?	◯	◯
Have your teeth been professionally cleaned regularly?	◯	◯
Do you have any questions or a special request?	◯	◯

Please understand that appointments that cannot be kept must be canceled at least 24 hours in advance

_____

Date/Place Signature