Medical History

Dental practice Neuwiesen

□ Mrs, Ms
□ Mr
• First name _____ Family name _____
• Address: Street, No. _____
ZIP, Place _____
• Phone: private _____ at work _____
mobile _____
• E-Mail _____
• Date of birth _____
• Profession _____
• Nationality _____ Residence permit _____
Physician: Name and Place _____

If younger than 18 years: Parent
□ Mrs, Ms □ Mr
• First name _____ Family name _____
• Address: Street, No. _____
ZIP, Place _____

- Recipient of social benefits? (public welfare, IV etc.)..... □ yes □ no
- Reason of consultation _____

Please fill in the form about your health condition truthfully
- Are you under medical treatment? reason? _____ □ yes □ no
- Do you need medication regularly? what? _____ □ yes □ no
- Do you suffer from immune deficiency? (HIV, chemotherapy, leucaemia etc.)..... □ yes □ no
- Past or current infectious disease? (hepatitis etc.) ..... □ yes □ no
- Allergic reactions? (injections, drugs etc.)..... □ yes □ no
- Bleeding disorders or drugs causing coagulation disorders?
(haemophilia, leucaemia, aspirin, painkillers, coumarins etc.) ..... □ yes □ no
- Heart or vascular disease?
(high blood pressure, heart failure, dyspnea during exercise, circulation disorders etc.) .. □ yes □ no
- Do you need an endocarditis prophylaxis? ..... □ yes □ no
- Do you suffer from diabetes? ..... □ yes □ no
- Do you suffer from kidney disease? ..... □ yes □ no
- Do you suffer from pulmonary disease? (asthma, COPD etc.)..... □ yes □ no
- Other health disorders? which? _____ □ yes □ no
- Do you smoke? if yes, how many cigarettes a day? _____ □ yes □ no
• For female: are you pregnant? which week of pregnancy? _____ □ yes □ no

Do you wish a reminder of appointments and recalls? ..... □ yes □ no

By what have you become aware of our dental practice?
□ newspaper/flyer □ internet □ relatives/friends □ other _____

The information about your health condition will be used for internal practice use only und is treated in confidence and medical confidentiality. Information of other institutions is done by your consent only (insurances, public welfare, referral etc.).
I confirm the accuracy of my statement

place and date _____ signature _____

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