ZAHNARZTPRAXIS SCHÄF

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Medical history questionnaire

Dear patient!
Before we sit down to talk about your dental wishes, we require information about your general state of health, in addition to your personal details. This is because even general illnesses can impact on the dental treatment. We therefore ask you to complete this questionnaire. Of course, all the information you provide is subject to medical confidentiality.

Personal details

Surname / first name _____

Address _____ Postcode / place _____

Date of birth _____ Place of birth _____

Tel. (landline) _____ Tel. (mobile) _____

Email _____ Occupation _____

Health insurance company / private health insurance company _____

legally insured ❍ yes ❍ no additional insurance ❍ yes ❍ no

privately insured ❍ yes ❍ no eligible for benefit ❍ yes ❍ no basic rate ❍ yes ❍ no

If you yourself are not the health insurance policy holder, please state whose insurance you are covered under.

Surname / first name _____ Date of birth _____

Address _____ Postcode / place _____

Who is your general practitioner?

Name _____ Place _____

Tel. _____

Organisational details

We are an appointment-based practice – that means we reserve the time for your appointment specially for you. So we ask that you cancel appointments you are unable to keep 24 hours beforehand at the latest – otherwise you may be charged for the costs arising from your failure to appear.

Advice on fitness to drive after dental treatments

Please be aware that your fitness to drive may be impaired for up to 24 hours after a dental treatment. This can be caused both by the treatment itself and by the influence of injections or other medications. Therefore, if you wish, we would be happy to call a taxi for you to bring you home safely.
In rare cases, using local anaesthetic in the lower jaw area can lead to irritation of the nerves in the lower jaw. This can manifest itself as persistent numbness in the lips and tongue over days/weeks. The dentist has no influence on this, it is a result of each individual patient's anatomical conditions.

About us

How did you find out about our practice?

❍ Recommended by acquaintances ❍ telephone book / business directory ❍ newspaper advertisement

❍ Referred by _____

❍ Internet, via the site _____ ❍ other _____

Would you like to receive our practice newsletter via e-mail? ❍ yes ❍ no

Would you like to receive a reminder about your appointment? ❍ no yes, by ❍ text ❍ email ❍ phone

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

❍ routine check-up ❍ new dentures
❍ consultation ❍ "second opinion"
❍ pain treatment ❍ other reasons:

_____

Do you have acute pain? ❍ yes ❍ no

Do you suffer from or have you suffered from diseases of the...

circulation	❍ yes	❍ no
liver	❍ yes	❍ no
kidneys	❍ yes	❍ no
thyroid	❍ yes	❍ no
gastrointestinal tract	❍ yes	❍ no
joints (rheumatism)	❍ yes	❍ no
spine	❍ yes	❍ no

Do you have or have you had...

high blood pressure	❍ yes	❍ no
low blood pressure	❍ yes	❍ no
diabetes	❍ yes	❍ no
bleeding of the gums	❍ yes	❍ no
buzzing in the ears / tinnitus	❍ yes	❍ no
osteoporosis	❍ yes	❍ no
epilepsy	❍ yes	❍ no
glaucoma	❍ yes	❍ no
tuberculosis	❍ yes	❍ no
HIV (Aids)	❍ yes	❍ no
hepatitis	❍ yes	❍ no
If so, which type?	❍ A ❍ B	❍ C
allergies	❍ yes	❍ no
If so, to what? _____		
a prosthetic joint (e.g. artificial knee or hip joint)	❍ yes	❍ no
If so, where exactly? _____		

Other infections / illnesses:

_____

About your heart: Do you have or have you had...

❍ stents ❍ bypass
❍ pacemaker ❍ heart attack
❍ endocarditis ❍ artificial heart valve
❍ angina pectoris ❍ _____

Medications: Do you take...

❍ heart medication ❍ cortisone (corticoids)
❍ painkillers ❍ antidepressants
❍ blood-thinning medications, e.g. Marcumar®, ASS?
❍ other medications:

_____

Have you ever shown incompatibilities towards medications or injections?

❍ yes ❍ no

If so, towards which ones?

_____

For our female patients

Are you pregnant? ❍ yes ❍ no

If so, how many weeks pregnant are you?

_____

Finally

Do you grind your teeth? ❍ yes ❍ no
Do you smoke? ❍ yes ❍ no

Questions / queries:

_____

_____

By signing, I consent to the treatment, and to the use of my patient data by the treating dentists at the Schäf dental practice.

I hereby consent to my personal data being stored by the practice for check-ups. I have been informed that I can withdraw my consent at any time in writing or by sending an email to the practice (article 7, para. 3 of the GDPR).
I understand that withdrawing my consent at any time does not affect the legality of the data processed based on my consent up until the point it was revoked (article 7, para. 3, clause 2 of the GDPR).

I have filled out this questionnaire to the best of my knowledge and belief, and confirm the completeness and accuracy of the information with my signature. I will advise you of any changes promptly.

_____
Date Signature