Zahnarzt

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Surname . . . . . .
First name . . . . . .
Date of birth . . . . . .

Telephone No.:.....

Patient questionnaire

The answers to the following questions are of great importance for your treatment. If you have any questions, feel free to contact the dentist on duty.

✍ **Please mark whether the following topics are applicable to you:**	**Yes**	**No**
1. Did any accident occur at work or at school?	❑	❑
2. Has there been any change in your general health within the past year or did you loose weight significantly?	❑	❑
3. Have you been in medical treatment lately? Your family doctor? . . . . . Your dentist?	❑	❑
4. Do you take any medical drugs regularly? If yes, please name them on the back of this form.	❑	❑
5. Are there any allergy tendencies (incompatibilities)?	❑	❑
6. Do you have any heart disease, cardiac defect or any complaint in the region of the heart?	❑	❑
7. Do you have hypertension? (Do you know your blood pressure? . . . . . .)	❑	❑
8. Do you have a cardiac pacemaker?	❑	❑
9. Did you or do you have any respiratory ailment or lung disease (asthma, tuberculosis)?_____	❑	❑
10. Are you diabetic?	❑	❑
11. Do you have any blood coagulation deficiencies or prolonged bleeding at injuries?	❑	❑
12. Do you have any thyroid gland disease? hyperfunction ❑ hypofunction ❑	❑	❑
13. Do you or did you have any nephropathy?	❑	❑
14. Do you or did you have any liver disease (icterus, hepatitis A, - B, - C)?	❑	❑
15. Did you have any blackout, faint or seizure (apoplexy, epilepsy)?_____	❑	❑
16. Do you have a glaucoma?	❑	❑
17. Did you have an acute rheumatic fever?	❑	❑
18. Do you need any antibiotics before dental treatment?	❑	❑
19. Do you have any infectious disease?	❑	❑
20. Have you ever been tested for HIV (AIDS)?	❑	❑
21. Do you suffer from any discomfort or disease not mentioned here?	❑	❑
22. Females: Are you pregnant or is there any possibility of being pregnant?	❑	❑
23. You come - for consultation	❑	❑
- for emergency treatment	❑	❑
- for sanitation (extensive treatment in our dental policlinics)	❑	❑
- because of referral of	❑	❑
24. Have you been in dental treatment last year?	❑	❑

Your remarks, complements, requests: . . . . . **Date Signat**

überprüft/aktualisiert: *Datum:* . . . . . *Behandler:* . . . . . .