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MEDICAL HISTORY AND CONSULTATION QUESTIONNAIRE

Dear Patient,
Please take a few minutes of your time to answer all of the following questions. Filling in this questionnaire is an important contribution so that we can judge the state of your health reliably. Thus, we'll be able to provide better consultation and select the right treatment for you.

PERSONAL INFORMATION OF INSURED PERSON

Name, First Name ______________________

Date of Birth ______________________

Address ______________________

Phone (private) ______________________

Mobile ______________________

Email ______________________

Profession ______________________

Health Insurance ______________________

OVERALL MEDICAL HISTORY

Do you regularly take medication? ☐ Yes ☐ No

If so, which ones? ______________________

____

Are there any medications you don't tolerate? ☐ Yes ☐ No

If so, which ones? ______________________

____

Do you suffer from a cardiovascular illness (heart)? ☐ Yes ☐ No

Do you suffer from an infectious disease (hepatitis, HIV, etc.)? ☐ Yes ☐ No

Do you suffer from a metabolic illness (diabetes, etc)? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No

If so, which ones? ______________________

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For our female patients: Are you pregnant? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

If so, how many cigarettes per day? ______________________

____

PLEASE TURN OVER →

DENTAL MEDICAL HISTORY

Did you ever...

... experience problems after dental anaesthesia?	☐ Yes	☐ No
... have problems with your gums (bleeding, receding gums)?	☐ Yes	☐ No
Did you undergo a gingival treatment during the past 5 years?	☐ Yes	☐ No
Have you ever had problems when opening your mouth (grinding, snapping)?	☐ Yes	☐ No
Have you or a person close to you ever noticed that you grind your teeth or frequently clamp your teeth together?	☐ Yes	☐ No
Do you have children?	☐ Yes	☐ No

If so, how old are they? ______________________________

CONSULTATION

Would you like to receive more information about caries or parodontitis prophylaxis for yourself and your children?	☐ Yes	☐ No
Are you happy with the way your teeth look?	☐ Yes	☐ No

If not, why not (e.g. colour, shape, position of teeth)? ______________________________

____

Would you like to get advice on a special topic?

- ☐ Yes, about invisible fillings
- ☐ Yes, about ceramic and gold inlays
- ☐ Yes, about amalgam replacement
- ☐ Yes, about implants
- ☐ Yes, about inhalation sedation with laughing gas
- ☐ Yes, about the future of my teeth

Would you like us to remind you of prophylaxis appointments? ☐ by phone ☐ by SMS ☐ written form

Was our practice recommended to you? ☐ Yes ☐ No

If so, by whom? ______________________________

Thank you!

Once again, thank you very much for filling in this questionnaire.

If answering one or more questions was difficult or unclear, please tell us about it.

______________ ______________________________

Date Signature