Health questionnaire

Name: _____ Date of birth: _____

Email: _____ Tel.: _____

Dear patients!

Your visits to the doctor should be as pleasant as possible!
At our surgery, you will receive optimal and individual dental advice and treatment!
For this reason, however, we require precise information about your general state of health and **all** medicines that you are taking.

You answers will be treated confidentially. They are subject to the obligation of medical secrecy and data protection regulations and will be used exclusively in connection with the treatment in our surgery!
Do you have any questions? We will be pleased to help you complete the form!

GP/specialist: Telephone _____

Address _____

Please indicate with a cross all current and/or overcome illnesses/anomalies.

Heart	□ no	□ yes	□ Heart attack	When _____
			□ Stent/bypass	
			□ Angina pectoris	When _____
			□ Heart pains	
			□ Heart defect	
			□ Cardiac insufficiency	
			□ Breathing difficulties during physical activity	
			□ Myocardial disease	
			□ Cardiac dysrhythmia	
			□ Valvular infection/ defect	
			□ Heart valve replacement	
			□ Pacemaker/impl.	
			□ Defibrillator	
			□ Heart operation	
	What kind of heart medicine do you take:			
Vessels	□ no	□ yes	□ Stroke	When _____
			□ Thrombosis	
			□ Embolism	
			□ Circulatory disorder	
	What kind of medicine do you take:			
Circulatory system	□ no	□ yes	□ High blood pressure/hypertension	
			□ Low blood pressure/ hypotension	
			□ Fainting spells/collapse	
	What kind of medicine do you take:			
Lungs and respiratory system	□ no	□ yes	□ Pneumonia	
			□ Bronchial asthma	
			□ Allergic asthma	

□ Dry cough
□ Tuberculosis
□ Chronic bronchitis, COPD
□ Sleep apnoea

What kind of medicine do you take:

Allergies/ hypersensitivity □ no □ yes
□ Medicines
□ Lactose/fructose/ milk sugar
□ Latex
□ Other: _____

Kidneys □ no □ yes
□ Kidney inflammation/ insufficiency
Dialysis: on which days:
□ Mo □ Tu □ We □ Th □ Fr □ Sa □ Su
□ Registered for transplantation

What kind of medicine do you take:

Liver □ no □ yes
□ Hepatitis □ A □ B □ C
□ Fatty liver
□ Liver dysfunction

What kind of medicine do you take:

Metabolism □ no □ yes
□ Diabetes mellitus □ Type1 □ Type2

□ Insulin
□ Oral medicines
□ Diet

□ Overactive thyroid
□ Underactive thyroid
□ Goitre

What kind of medicine do you take:

Blood □ no □ yes
□ Coagulation disorder
□ Bruises, nosebleed
□ Secondary bleeding after operations
□ Blood cancer, e.g. leukaemia
□ Anaemia

What kind of medicine do you take:

Nerves and mood □ no □ yes
□ Seizures
□ Paralyses
□ Mental disability
□ Parkinson's disease
□ Depression
□ Dementia
□ Anxiety
□ Stress

What kind of medicine do you take:

Gastrointestinal tract	□ no	□ yes	□ Ulcer □ Indigestion, reflux disease □ Halitosis (bad breath)
	What kind of medicine do you take:		
Skeletal system	□ no	□ yes	□ Joint disease □ Backache □ Muscular disease □ Physical disability □ Wheelchair/ walking frame □ Osteoporosis
	What kind of medicine do you take:		
Infection	□ no	□ yes	□ Influenza, flu-like infection □ HIV infection □ Aphthae □ Lip herpes □ Shingles
	What kind of medicine do you take:		
Eyes	□ no	□ yes	□ Visual impairment □ Cataract □ Glaucoma
	What kind of medicine do you take:		
Other illnesses/ anomalies	□ no	□ yes	□ Tumour illness □ Rheumatic illnesses □ Transplants
	What kind of medicine do you take:		
Smoking	□ no	□ yes	How many on average per day
Alcohol	□ no	□ yes	□ occasionally □ regularly
Drugs	□ no	□ yes	□ occasionally □ regularly Which
Pregnancy	□ no	□ yes	Which week

Important: *Please indicate all kinds of medicine you take, including homeopathic medicines, contraceptive pill, etc.!*

_____ _____

Signature **Date**