Praxis für Zahnheilkunde
Daniela Hoerr

Name, First Name: ______________________
Date of Birth: ____________________

Medical History Form

X-Ray

When was the last time you have a X-ray of you head/jaw area? ☐ Yes ☐ No

____

Do you own a X-ray Pass? ☐ Yes ☐ No

For patients

Are you pregnant? ☐ Yes ☐ No

If yes, what month? _____________________

General Health Question

Are you under constant medical treatment? ☐ Yes ☐ No

If yes, why? ____________________________

Get Bruise easily? ☐ Yes ☐ No

Do you suffer from wounds that heal poorly? ☐ Yes ☐ No

Do you suffer from prolonged bleeding after injuries? ☐ Yes ☐ No

Crepitation ☐ Yes ☐ No

Do you wear a bite device/splint? ☐ Yes ☐ No

Cardiovascular diseases

☐ Low blood pressure ☐ High blood pressure

Cardiac pacemaker ☐ Yes ☐ No

Endocarditis ☐ Yes ☐ No

Valvular heart defect/transplant ☐ Yes ☐ No

Angina Petritois ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Bleeding disorder ☐ Yes ☐ No

Do you own a heart pass? ☐ Yes ☐ No

Heartattack ☐ Yes ☐ No

If yes, when? ____________________________________

Cardiac defect ☐ Yes ☐ No

If yes, what? ____________________________________

Tumor ☐ Yes ☐ No

If yes, what?___________________________________

Was it operated? ☐ Yes ☐ No

Chemotherapy ☐ Yes ☐ No

Radiotheraphy ☐ Yes ☐ No

_____ ____________ ____________________

Date Sign

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Vegetative and chronic diseases

Dizziness	☐ Yes ☐ No
Fainting fit	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Diabetes/Lung disease_ Typ:__________	☐ Yes ☐ No
Gastro-intestinal disease	☐ Yes ☐ No
Diseases of the kidney or anomalies	☐ Yes ☐ No
Rheuma/Arthritis	☐ Yes ☐ No
Tinnitus	☐ Yes ☐ No
Glaucoma (green Star)	☐ Yes ☐ No
COPD (Chronic obstructive pulmonary disease))	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No
Mutiple sclerosis (MS)	☐ Yes ☐ No
Depression, Anxiety	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No
Do you feel physically stressed?	☐ Yes ☐ No
Do you fell psychological stresses ?	☐ Yes ☐ No

disease of the thyroid gland etc.____________________ ☐ hyperfunction ☐ hypofunction

Infections diseases

☐ HIV ☐ Hepatitis (A, B, C) ☐ Tuberculosis

Taking regulary medication

☐ Bloodthinner (z.B ASS, Marcumar, Eliqus) ☐ Cortison

☐ Heartmeds ☐ Painkiller ☐ Antidepressant

Other: ☐ Yes ☐ No

If yes, what? ___________________________________

Did you ever take Bisphosphonates? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

If yes, how many cigarettes a day? ____________________

Do you snore? ☐ Yes ☐ No

Do you have an Allergypass? ☐ Yes ☐ No

Are you allergic/intolerance to specifc medication/substances ☐ Yes ☐ No

(z.B painkiller, penicillin, iodine, latex, local anesthesia) ?

If yes, what? ____________________________________

Do you want us to recall you the routine checkup regularly? ☐ Yes ☐ No

☐SMS ☐Email ☐Postcards

_____ ___________ ________________

Date Sign