



Medical history

Welcome to!

Before we talk alone about your dental needs, we also need in addition to your personal information about your general health. This is important for an adequate and risk-free treatment. All information subject to medical confidentiality, thank you.

name	first name	birthday	
PLZ	city	street	
phone	mobile phone	phone at work	email
health insurance	name of the member	birthday	
dentist	address	other doctors	

Have you ever had one of the diseases listed below?

	Yes	No		Yes	No
diabetes	<input type="radio"/>	<input type="radio"/>	low blood pressure	<input type="radio"/>	<input type="radio"/>
blood disease	<input type="radio"/>	<input type="radio"/>	high blood pressure	<input type="radio"/>	<input type="radio"/>
infection disease (HIV, Hepatitis A,B,C)	<input type="radio"/>	<input type="radio"/>	heart disease		
			- congenital heart fail	<input type="radio"/>	<input type="radio"/>
			- heart valves fail, - prosthesis	<input type="radio"/>	<input type="radio"/>
thyroid disease	<input type="radio"/>	<input type="radio"/>	- endocarditis	<input type="radio"/>	<input type="radio"/>
			- heart operations	<input type="radio"/>	<input type="radio"/>
lung disease	<input type="radio"/>	<input type="radio"/>	- pacemaker	<input type="radio"/>	<input type="radio"/>
asthma	<input type="radio"/>	<input type="radio"/>	Take you medicament for blood clotting? (ASS, Marcumar)	<input type="radio"/>	<input type="radio"/>
nerve disease	<input type="radio"/>	<input type="radio"/>	Can you tolerate certain medicaments or narcotics? _____	<input type="radio"/>	<input type="radio"/>
Liver disease	<input type="radio"/>	<input type="radio"/>	_____		
rheumatism	<input type="radio"/>	<input type="radio"/>	Have you some allergies? _____	<input type="radio"/>	<input type="radio"/>
kidney disease	<input type="radio"/>	<input type="radio"/>	_____		
epilepsy	<input type="radio"/>	<input type="radio"/>	Take you medicaments at the moment?	<input type="radio"/>	<input type="radio"/>
gastrointestinal disease	<input type="radio"/>	<input type="radio"/>	_____		
eye disease	<input type="radio"/>	<input type="radio"/>	_____		
Have you had a tumor with radiation treatment?	<input type="radio"/>	<input type="radio"/>	for female: Are you pregnant?	<input type="radio"/>	<input type="radio"/>
Have you some other disease?	<input type="radio"/>	<input type="radio"/>	Breastfeed your baby?	<input type="radio"/>	<input type="radio"/>
_____			_____		
_____			date		sign