Medical History Form

ZAHNREICH

Dear patient,

please fill in the medical history form thoroughly. All information provided is subject to medical confidentiality.

Last name / first name _____

Address _____ Postal code / City _____

Date of birth _____ Place of birth _____

Telephone – private / work _____ / _____

E-Mail _____ Occupation _____

Health insurance / insurance _____

Was our practice recommended to you? ❍ yes ❍ no If yes, by whom? _____

Reason for your visit

❍ Routine check ❍ Consultation ❍ Pain treatment ❍ Prostheses

❍ Other reasons: _____

Do you have or did you ever have one or more of the following medical conditions?

Asthma	❍ yes	❍ no		
Allergies	❍ yes	❍ no	If yes – which? _____	
Blood pressure	❍ normal	❍ low	❍ high	Value: _____
Diabetes	❍ yes	❍ no		
Cardiac and circulatory disorders	❍ yes	❍ no		
Heart defect, pacemaker	❍ yes	❍ no		
Stroke	❍ yes	❍ no	If yes – when? _____	
Do you have any infectious disease? If yes – which? (Hepatitis, HIV/AIDS, TBC, etc.) _____			❍ yes	❍ no
Do you have a tendency to post-operation bleeding?			❍ yes	❍ no
Do you take medication regularly? If yes – which? _____			❍ yes	❍ no
Do you suffer from any medical conditions not listed? If yes – which? _____			❍ yes	❍ no
Are you pregnant?	❍ yes	❍ no	If yes – what week? _____	
Do you smoke?	❍ yes	❍ no		

It has been brought to my attention that my ability to drive can be impaired for 4-6 hours under the influence of injections for local anaesthesia, therapeutic injections and drugs, administered prior or during the treatment. I have been informed that time has been reserved for me for the agreed upon appointments. It is therefore absolutely necessary to keep the appointments agreed upon. In case I should not be able to keep an appointment I will cancel it 24 hours in advance.

❍ I consent to the data I have provided being used for the sending of mail and e-mail.

❍ I confirm the accuracy of the information I have provided to the best of my knowledge.

_____

Date and signature