ZAHNÄRZTE
IN DER
HOLTENAUER

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Medical history form

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Patient data

Name, first Name: _____

Date of birth: _____

Residential address: _____

Phone number: _____

E-mail address: _____

insured

Name, first Name: _____

Date of birth: _____

Residential address: _____

Cardiovascular diseases

(ja) (nein) High blood pressure?
if yes, what medicines do you take? _____

(ja) (nein) Low blood pressure?
if yes, what medicines do you take? _____

(ja) (nein) Valvular heart disease?
if yes, what medicines do you take? _____

(ja) (nein) Pacemaker?
if yes, what medicines do you take? _____

(ja) (nein) Endocarditis?
if yes, what medicines do you take? _____

Infections diseases

(ja) (nein) HIV?
if yes, what medicines do you take? _____
(ja) (nein) Hepatitis?
if yes, what medicines do you take? _____
(ja) (nein) Creutzfeld jacob diseases?
if yes, what medicines do you take? _____
(ja) (nein) Tuberculosis?
if yes, what medicines do you take? _____
(ja) (nein) Multidrug resistant bacteria?
(ja) (nein) Other? _____

Allergies / Intolerances

(ja) (nein) Local anesthetics?
if yes, which one? _____
(ja) (nein) Antiboitics?
if yes, which one? _____
(ja) (nein) Painkiller?
if yes, which one? _____
(ja) (nein) Other? _____

More diseases

(ja) (nein) Blood clotting disorder?
if yes, what medications do you take? _____
(ja) (nein) Asthma?
if yes, what medications do you take? _____
(ja) (nein) Rheumatism?
if yes, what medications do you take? _____
(ja) (nein) Pulmonary disease?
if yes, what medications do you take? _____
(ja) (nein) Thyroid disease?
if yes, what medications do you take? _____
(ja) (nein) Epilepsy?
if yes, what medications do you take? _____
(ja) (nein) Diabetes?
if yes, what medications do you take? _____
(ja) (nein) Renal impairment?
(ja) (nein) Unconscious inclination?
(ja) (nein) Cataract?
(ja) (nein) Osteoporosis?
if yes, what medications do you take? _____
(ja) (nein) Cancer disease?
if yes, where and when are they in treatment? _____
(ja) (nein) Other? _____

General information

(ja) (nein) Other medicines?
if yes, what and what medicines do you use? _____
(ja) (nein) Take bisphosphonates?
(ja) (nein) Consume drugs?
(ja) (nein) Consume alcohol?
(ja) (nein) Smoke?
(ja) (nein) Are you insured with dental insurance?
(ja) (nein) There is a pregnancy?
if yes, which month? _____
(ja) (nein) Other? _____

Kiel, den ..... Unterschrift .....