Fachzahnärztliche Praxis Dr. Spörlein und Kollegen: Medical History

(please fill out consciously and completely)

Name:		Firstname:	
Date of Birth:		E-Mail:	
Phone:		Mobil Tel.:	
Street, No.:		Zip Code, City:	
Insurance:		Insured Person:	

☐ Public insurance ☐ Private Insurance ☐ Beihilfeberechtigt ☐ Additionale Insurance

Referring dentist: ____________ Prim. Physician: ____________

We kindly ask you to fill out this medical history form completely and carefully,as pre-exisiting conditions can have an impact on your dental treatment. This sheet will be added to your personal digital file. All of your information is subject to medical confidentiality.

Are you currently receiving medical treatment?	☐ Yes ☐ No	if yes, why?	
Do you have any general diseases?	☐ Yes ☐ No	if yes, which?	
Do you take medication regularly?	☐ Yes ☐ No	if yes, which?	
Do you take blood thinning medication?	☐ Yes ☐ No	if yes, which?	
Do you have allergies (medication/substances)?	☐ Yes ☐ No	if yes, which?	
Do you smoke?	☐ Yes ☐ No	if yes, how much?	
Are you currently or possibly pregnant?	☐ Yes ☐ No	if yes, which week?	
Do you have a joint prothesis?	☐ Yes ☐ No	if yes, which?	
Do you need endocarditis prophylaxis?	☐ Yes ☐ No		
Do you have a pacemaker?	☐ Yes ☐ No		

Do you have any of these following diseases?

☐ High Bloodpressure (Hypertonie)	☐ Thyroid Disease	☐ Circulatory Disease
☐ Low Bloodpressure (Hypertonie)	☐ Liver Disease	☐ Nerve Disease
☐ Virusinfection (HIV/Hepatitis)	☐ Lung Disease	☐ Epilepsy
☐ Bonedisease (Osteoporosis)	☐ Kidney Disease	☐ Stomach-intestine-disease
☐ Diabetic Disease	☐ Rheumatoid arthritis	☐ increased intraocular disease

☐ Other disease which were not listed: ____________

Dental self-assessment

Do you have pain in the head neck area?	☐ Yes ☐ No	Do you suffer from ear noises?	☐ Yes ☐ No
Do you have pain when chewing or yawning?	☐ Yes ☐ No	Do you have toothache right now?	☐ Yes ☐ No
Do your jaw joints make noises (crack)?	☐ Yes ☐ No	Do your gums bleed?	☐ Yes ☐ No
Do you grind with your teeth?	☐ Yes ☐ No	Would you like to sleep during your treatment?	☐ Yes ☐ No

Are you interested in prophylactic treatments? ☐ Yes ☐ No

Are you interested in our yearly recall programm (reminder for annual check-up) ☐ Yes ☐ No

I confirm that I have read and understood the privacy policy.

Thank you for your information and honesty.

City, Date: ____________ Signature: ____________