

HEALTH QUESTIONNAIRE

surname

first name

date of birth/city

Dear patients,

you are optimally and individually advised and treated with dental medicine at our surgery! For this, we need accurate information about your current state of health and all medications you take. With your answers, we will deal confidentially. They are subject to medical confidentiality as well as to data protection and serve exclusively for the treatment in our surgery!

Diseases

family doctor

phone

Contact for further information?

yes no

Have or had you any of these diseases?

	yes	no		yes	no
heart attack	<input type="radio"/>	<input type="radio"/>	tuberculosis	<input type="radio"/>	<input type="radio"/>
stents / bypass	<input type="radio"/>	<input type="radio"/>	tumor diseases / cancer	<input type="radio"/>	<input type="radio"/>
angina pectoris	<input type="radio"/>	<input type="radio"/>	metabolic disease	<input type="radio"/>	<input type="radio"/>
endocarditis	<input type="radio"/>	<input type="radio"/>	thyroid disease	<input type="radio"/>	<input type="radio"/>
heart valve replacement	<input type="radio"/>	<input type="radio"/>	diabetes	<input type="radio"/>	<input type="radio"/>
arrhythmia	<input type="radio"/>	<input type="radio"/>	rheumatism	<input type="radio"/>	<input type="radio"/>
high blood pressure	<input type="radio"/>	<input type="radio"/>	osteoporosis	<input type="radio"/>	<input type="radio"/>
low blood pressure	<input type="radio"/>	<input type="radio"/>	HIV	<input type="radio"/>	<input type="radio"/>
heart pacemaker / defibrillator	<input type="radio"/>	<input type="radio"/>	hepatitis A, B or C	<input type="radio"/>	<input type="radio"/>
Do you have a heart passport?	<input type="radio"/>	<input type="radio"/>	head or neck pain	<input type="radio"/>	<input type="radio"/>
stroke	<input type="radio"/>	<input type="radio"/>	migraine	<input type="radio"/>	<input type="radio"/>
bronchial asthma	<input type="radio"/>	<input type="radio"/>	depression / anxiety	<input type="radio"/>	<input type="radio"/>

Allergies? which substances? _____

yes no

Are there any other diseases? _____

yes no

Do you take any medication?

yes no

Yes? Which one? _____

Do you have a medication list?

yes no

Are you pregnant?

yes no

Do you smoke?

yes no

Cologne date of

Signature