DOCTOR
MELCHIOR & TEAM
ZAHNÄRZTE IM MEDIAPARK

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
heart attack	○	○
stents / bypass	○	○
angina pectoris	○	○
endocarditis	○	○
heart valve replacement	○	○
arrhythmia	○	○
high blood pressure	○	○
low blood pressure	○	○
heart pacemaker / defibrillator	○	○
Do you have a heart passport?	○	○
stroke	○	○
bronchial asthma	○	○

	yes	no
tuberculosis	○	○
tumor diseases / cancer	○	○
metabolic disease	○	○
thyroid disease	○	○
diabetes	○	○
rheumatism	○	○
ostheoporosis	○	○
HIV	○	○
head or neck pain	○	○
migraine	○	○
depression / anxiety	○	○
hepatitis A, B or C	○	○

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