UWE FRINGS
ZAHNARZT PRIVATPRAXIS

QUESTIONNAIRE ON GENERAL HEALTH STATUS

You are asked to complete the following questionnaire on your general health status to assist the dentist in his treatment and to avoid possible complications. The dentist and his staff will treat any information provided by you in strictest confidence. If you cannot, or do not wish to complete all the questions, you will have the opportunity to discuss this and any queries you may have with the dentist.

Patient ..... (Name / First Name / Date of Birth)

..... (Name / First Name / Date of Birth)

Address ..... (Street / No.)

..... (Area code / City / Email)

Telephone ..... (Telephone / Fax / Cellphone)

Insurance .....

Occupation .....

Company ..... (Telephone)

Address Company .....

What is the purpose of your visit?

.....

.....

1. Are you currently receiving medical treatment? ❑ YES ❑ NO

.....

2. Are you currently taking any medications? ❑ YES ❑ NO
(If yes, please indicate which.)

.....

3. Are you allergic to any substances or medications? ❑ YES ❑ NO
(e. g. Penicillin)

.....

4. Have you ever had a bad reaction to a local anaesthetic? ❑ YES ❑ NO

5. Have you ever suffered from nausea/dizziness/fainting during a dental treatment? ❑ YES ❑ NO

6. Does anyone in your family suffer from bleeding/blood clotting problems? ❑ YES ❑ NO

7. Do you suffer from excessive bleeding after doctor`s treament? ❑ YES ❑ NO

8. Do you take medication for blood clotting problems? ❑ YES ❑ NO

9. Have you suffered from the following illnesses:

High/low blood pressure	❑ YES ❑ NO
Heart problems	❑ YES ❑ NO
Heart attack	❑ YES ❑ NO
Lung problems	❑ YES ❑ NO
Diabetes	❑ YES ❑ NO
Liver problems	❑ YES ❑ NO
Kidney problems	❑ YES ❑ NO
Thyroid problems	❑ YES ❑ NO
Epilepsy	❑YES ❑ NO
Rheumatics	❑ YES ❑ NO
Infectious Diseases (e.g. Hepatitis, AIDS, TB)	❑ YES ❑ NO
Other illnesses	❑ YES ❑ NO

10. Only for female patients: Are you pregnant ? ❑ YES ❑ NO

11. When were you last x-rayed by a doctor or dentist? .....

Please inform your dentist, before each treatment, if your health status has changed. You may review this questionnaire prior to future treatments to refresh your memory, should you so wish.

Geilenkirchen, ...
Date Signature

Besprochen: ....
Datum Unterschrift