MEDICAL HISTORY QUESTIONNAIRE

Dr. K. Tilo Bartels – Dentist, Oral Surgeon
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Welcome to our practice!

Dear Patient,
Please take your time filling out this **two page** questionnaire. It is of utmost importance that you answer all the questions regarding the status of your health to the best of your knowledge. Should there be any significant changes to those details given, we would request that you notify us immediately. All information given will be treated with confidentiality. Many thanks for your cooperation.
Your Dr. Bartels

Patient	Name	Surname	Date of Birth
Member	Name	Surname	Date of Birth
Patient's Address	Street	City	e-mail
Member's Adress	Street	City	e-mail
Business Adress	Street	City	e-mail
Telephone	private	work//daytime	

Occupation

Name of Healt Insurance

- ☐ Compulsory member
- ☐ Private supplement insurance
- ☐ Private health insurance
- ☐ Voluntary insured member
- ☐ Aided
- ☐ Not insured

Who recommended or referred you to us?

Doctor's name and address, or telephone number?

Are you currently under the care of any other doctor or therapist or receiving any regular treatment? Due to what reason?

Please turn over >

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What **medication** are you taking now?	
Are you **allergic** to anything?	
Do you have an **allergy passport**?	☐ yes / no ☐
Do you suffer from **asthma**?	☐ yes / no ☐
Have you suffered from **prolonged bleeding** during a dental or surgical operation?	☐ yes / no ☐
Do you take any anticoagulant medication (e.g. marcumar, aspirin)?	☐ yes / no ☐
Do you drink more than three beers or two glasses of wine per day?	☐ yes / no ☐
Do you smoke?	few ☐ / many ☐ / no ☐
Do you take drugs?	☐ yes / no ☐
Have you ever suffered from any **heart complaint**?	☐ yes / no ☐
Do you have a **pacemaker** or a **heart valve replacement**?	☐ yes / no ☐
Do you suffer from **high blood pressure**?	☐ yes / no ☐
Were you ever suspected of having a **heart attack**?	☐ yes / no ☐
Do you take steroids or sedatives?	☐ yes / no ☐
Do you regularly suffer from headaches?	☐ yes / no ☐
Do you suffer from **epilepsy**?	☐ yes / no ☐
Do you have **diabetes**?	☐ yes / no ☐
Have you have a **thyroid illness**?	☐ yes / no ☐
Do you suffer from any eye diseases (i.e. **narrow-angle glaucoma**)?	☐ yes / no ☐
Do you suffer from **stomach or intestinal problems**?	☐ yes / no ☐
Did you ever have a **liver disease** (jaundice / hepatitis)?	☐ yes / no ☐
Did you ever have **kidney disease**?	☐ yes / no ☐
Did you ever have **tuberculosis** or a **genital illness**?	☐ yes / no ☐
Is it possible that you are **HIV positive**?	☐ yes / no ☐
Were you ever operated on you **sinuses** (i.e. nasal cavity)?	☐ yes / no ☐
Do you have problems with your locomotor system (i.e.cervical spine)?	☐ yes / no ☐
Was your **head area** ever injured or operated on?	☐ yes / no ☐
Were you ever treated for a tumour?	☐ yes / no ☐
Other illnesses?	☐ yes / no ☐
If yes, which?	
Have you had an x-ray within the past twelve months?	☐ yes / no ☐
If yes, which area of the body?	
Are you **pregnant** or is it possible you are pregnant?	☐ yes / no ☐
Additional information relevant to your treatment?	

Please note the following: It is unadvisable to drive a vehicle three hours after receiving an injection of any kind!

Date ..... Signature.....