MEDICAL HISTORY REGARDING DENTAL AND ORAL TREATMENT, NEW CUSTOMER

Several conditions, illnesses and medications may have an effect on your dental care. That is why it is important to fill in the following sections carefully. The information you supply is confidential.

Name _____ Personal identity code _____

Please inform the customer service or the personnel in charge of your treatment if your contact information has changed

Does your employee/company have a dental care plan? No ☐ Yes ☐ _____
Are you a member of a sickness fund? No ☐ Yes ☐ _____

Please send me an invitation to an oral and dental examination
☐ As a text message
☐ By mail
☐ By calling

GENERAL HEALTH

How would you describe your current health status? _____

Do you have any of the following diseases or conditions?

☐ Allergy (medication, food, rubber, etc.)? _____
☐ Complications during local anaesthesia? _____
☐ Cardiovascular disease? _____
  ☐ Infarction, please specify year: _____
  ☐ Pacemaker
  ☐ Valvular heart disease
  ☐ Artificial valve
  ☐ Heart failure
☐ Cerebral infarction
☐ High blood pressure
☐ Blood disorder, anemia
☐ Susceptibility to bleed? _____
☐ Diabetes? _____
  ☐ Long-term plasma glucose, HbA1c_____
☐ Respiratory disease? _____
☐ Bowel disease? _____
☐ Diseases of the musculoskeletal system? _____
☐ Organ transplant, year: _____
☐ Joint replacement/vascular prosthesis, year: _____
☐ Osteoporosis? _____
☐ Rheumatic disease? _____
☐ Kidney failure? _____
☐ Liver disease? _____
☐ Thyroid disease? _____
☐ Cancer? _____
☐ Chemotherapy/radiotherapy, year? _____
☐ Neurological disorder? _____
☐ Recurring headache or migraine_____
☐ Mental disorder? _____
☐ Visual or hearing impairment? _____
☐ Bloodborne infectious disease
☐ MRSA, VRE or another similar bacteria infection
☐ HIV infection, hepatitis? _____
☐ Other additional information? _____

Are you pregnant? No ☐ Yes ☐ due date? _____
Are you breastfeeding? No ☐ Yes ☐

REGULARLY USED MEDICATIONS AND POSSIBLE INJECTION TREATMENT

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

SMOKING AND USE OF INTOXICATING SUBSTANCES

On average, how many cigarettes do you smoke a day? _____cigarettes/day
If you use snuff, how many times a day you do it? _____times/day
On average, how many standard drinks (12 grams of pure alcohol) do you consume a week? _____drinks/week

PLEASE TURN -->

ORAL AND DENTAL HEALTH

Why are you currently seeking treatment? _____

When was the last time you had your entire mouth examined? _____

When was the last time you had your mouth and teeth treated? _____

How often do you brush?
☐ at least twice a day ☐ once a day ☐ less frequently

Do you use
☐ an electric toothbrush ☐ a manual toothbrush

How often do you clean between your teeth?
☐ at least once a day ☐ few times a week ☐ once or twice a week ☐ less frequently

Which of the following statements best describes your eating habits?
☐ I eat healthily and I have 4–6 meals a day.
☐ I eat healthily and I have 2–3 meals a day.
☐ I eat healthily and I have 2–3 meals a day, but I also enjoy snacks in between.
☐ I eat infrequently and enjoy snacks throughout the day.

If I am thirsty between meals, I drink _____

On a daily basis, I enjoy
☐ (unsweetened) juices and sodas ☐ sports and energy drinks ☐ coffee/tea with sugar

I am on a special diet. Please specify the diet: _____

_____
Date and signature