QUESTER
ZAHNÄRZTE IN DER MOHLSTRASSE

Welcome!

To make your visit as comfortable as possible, we need to know about any medical problems which may affect your dental treatment. Please fill in the questionnaire thoroughly and ask a member of our team if you require any assistance or have any questions.All information provided will be handled strictly confidentially.

Patient:

Surname: First name: Date of birth:

Street: Postcode: Town/City:

Health insurance company: Telephone: Mobile phone:

Parent or legal guardian:

Surname: First name: Date of birth:

Street: Postcode: Town/City:

May we remind you of your twice-yearly check-up?

- [ ] by postcard
- [ ] by text
- [ ] by email, address:

May we remind you of important appointments?

- [ ] by text
- [ ] by email, address:

State of health

Are you currently undergoing medical treatment? ☐ yes ☐ no

If "yes", why?

Doctor:

Medication

Are you taking any medication from your doctor?

please turn ➔

Heart problems

Heart insufficiency (heart failure)	☐ yes	☐ no
Irregular heartbeat	☐ yes	☐ no
Angina pectoris	☐ yes	☐ no
Cardiac valve replacement	☐ yes	☐ no
Pacemaker	☐ yes	☐ no

Cardiovascular problems

Hypertension (raised blood pressure)	☐ yes	☐ no
Hypotension (low blood pressure)	☐ yes	☐ no
Heart attack in the past	☐ yes	☐ no
Do you take anticoagulant medication?	☐ yes	☐ no

Infectious diseases

Hepatitis (A/B/C)	☐ yes	☐ no
HIV / AIDS	☐ yes	☐ no
Creutzfeldt-Jakob-Disease (CJD)	☐ yes	☐ no

Others medical conditions

Diabetes	☐ yes	☐ no
Thyroid disease	☐ yes	☐ no
Osteoporosis	☐ yes	☐ no
Haemophilia/bleeding problems	☐ yes	☐ no
Epilepsy	☐ yes	☐ no
Glaucoma	☐ yes	☐ no
Asthma	☐ yes	☐ no
Cancer/malignancy	☐ yes	☐ no

Do you smoke? ☐ yes ☐ no

Are you pregnant? ☐ yes ☐ no

Allergies? ☐ yes ☐ no

Do you have any allergies?

If "yes", which ones?

If you are unable to attend your appointment, please let us know 24 hours in advance.

Thank you!

Date

Signature