Evaluation form about general existing disease

Many general disease are able to effect the dental-medical treatment. Therefore we ask you to fill out this evaluation form. Please note the information provided is included within the medical oath and the requirement of confidentiality. We only collect these information for our dental treatment and to respond on your health. The information might be stored electronically if necessary. We do of course respect the strict regulations of privacy data protection.

patient: _____
name first name birthday

insured one: _____
name first name birthday health insurance

☐ compulsorily ☐ voluntary insurance ☐ privately insured: _____

address : _____
postal code place street phone number privat/ mobile phone number office.

e mail: _____ employer*: _____ job*: _____
* voluntary

name and address of her family doctor: _____

What kind of disease do you have / did you have?		Please, fill or mark yes	no
heart illnesses:	heart weakness (insufficiency) ……..…….....	☐	☐
	abnormal heart rhythm (arrhythmia) ……..…….....	☐	☐
	heart asthma / anginapectoris ……..…….....	☐	☐
	pacemaker …….....	☐	☐
circulatory illnesses:	too high blood pressure …….....	☐	☐
	too low blood pressure …….....	☐	☐
	heart attack, when?_____……	☐	☐
	taking of coagulation-restraining drugs , anticoagulant…….....	☐	☐
	fainting fits……..…….....	☐	☐
metabolism illnesses :	Diabetes ……..…….....	☐	☐
	gastrointestinal disease……..…….....	☐	☐
	thyroid gland disease…..…….....	☐	☐
illnesses of nerv system:	epileptic attacks / cramps ….....……..…….....	☐	☐
blood illnesses	bleeding inclination (haemophilia).....	☐	☐
	anaemia.....……..……	☐	☐
allergies:	eczemas ……..…….	☐	☐
	asthma ……..…….	☐	☐
	Penicillin-hypersensitivity ……..…….....	☐	☐
	Do you own an allergy ID? ……..…….....	☐	☐
	over-sensitive against _____	☐	☐
infection illnesses:	hepatitis A or B / jaundice.....……..…….....	☐	☐
	tuberculosis ……..……	☐	☐
	Chronic illnesses of the respiratory tract cough etc.…..……..……	☐	☐
	AIDS, HIV ……..……	☐	☐
Immunsystem disorder?	Do you suffer from illnesses of your immun-system? If so what kind? _____	☐	☐
Which drugs / medication are you taking momentarely?	_____		
Do you take drugs against bone-metabolism-disturbance as for example osteoporosis (bisphosphonate) or have you taken these in the past?		☐	☐
Forther information:	Are you pregnant? Which month? ….....…….	☐	☐
	Are you or were you addicted to drugs? ….....…….....	☐	☐
	Are you newly operated ?…….....	☐	☐
	When were you X-rayed for the last time? _____	☐	☐
	Do you own / want a X-ray ID?..…….……	☐	☐
	Which care products do you use for your dental care?_____ _____	☐	☐

Thank you for providing the information. **date: _____** **sign: _____**