Dr. med. dent.
Conrad Gast

MEDICAL HISTORY

Even general illnesses can have effects on dental treatment. Therefore, we ask you to answer the following questions about your state of health as precisely as possible. This form will be added to your patient file. The information you provide is subject to medical confidentiality and data protection regulations and will be treated in the strictest of confidence.

Patient:
Surname Name D.o.b Phone

Main insured person:
Surname Name D.o.b Phone

Adress:
Street Postcode Towns E-Mail

Occupation:
Employer* Phone business* (*this information is provided voluntarily)

GP:
Surname Address Phone

Do you have or have you had medical conditions relating to the following organs?
(Please check the relevant box.)

Heart:	**Yes**	**No**
Post heart attack		
Heart failure		
Myocarditis		
Endocarditis		
Cardiac arrhythmia		
Heart surgery		
Heart valve replacement		
Pacemaker		
Angina pectoris		
Stent		
Circulation:	**Yes**	**No**
Low blood pressure		
High blood pressure		
Circulatory disorders		
Stroke		
Blood diseases:	**Yes**	**No**
Anaemia		
Haemophiliac		
Leukaemia		
Respiratory tract / Lungs:	**Yes**	**No**
Asthma COPD		
Lung disease		
Tuberculosis		
Gastrointestinal tract:	**Yes**	**No**
Diseases of the stomach		
Bowel disease		

Bladder / Kidneys:	**Yes**	**No**
Bladder conditions		
Kidney disease		
Dialysis		
Liver:	**Yes**	**No**
Jaundice		
Hepatitis A B C D E		
Eyes:	**Yes**	**No**
Cataracts		
Glaucoma		
Locomotor system:	**Yes**	**No**
Rheumatism		
Rheumatoid arthritis		
Metabolism:	**Yes**	**No**
Diabetes		
Hyperthyroidism		
Hypothyroidism		
Osteoporosis		
Do you suffer or have you suffered from the following conditions?	**Yes**	**No**
Skin diseases or STDs		
HIV or AIDS		
Tumours (radiation, chemo or bisphosphonate therapy)		
Creutzfeldt-Jakob disease, kuru		

Other important medical information: (Please check the relevant box.)

1. Do you have any other illness not listed here? If yes, which ones?

2. Do you take any medication regularly? If yes, what do you take?

3. If you follow a medication regime, please bring it with you!

4. Do you consume alcohol regularly and / or take drugs? If yes, which?

5. Are you allergic to certain medications or other substances? If yes, which ones?

6. Do you have an allergy ID? Bring it with you!!

7. Did or do side effects occur after dental injections? If yes, which ones?

8. Do you suffer from epileptic seizures? **Yes** ☐ **No** ☐

9. Are you currently pregnant? **Yes** ☐ **No** ☐

10. Do you have a fully up-to-date bonus card? (Entries for the last 5 or 10 years)

I undertake to inform the practice immediately of any changes regarding my state of health or address. I further agree to the electronic storage, processing and forwarding of my data, if necessary, to debt collection agencies. Your personal data can also be used for quality assurance purposes.

Date **Signature**

I hereby undertake to attend appointments or to cancel at least 24 hours in advance. Failure to do so could result in charges being raised.

Date **Signature**