Dr. Leonie Brolund
Zahnärztin in Hamburg-Nienstedten

Medical History Form

A heartfelt welcome to our Dental Practice!

In order to discuss your Dental needs with you, we require the following information in relation to your medical history and general health. Providing us with a thorough background will ensure that you receive the right treatment.
Please also consider any upcoming changes that you are able to advise us of e.g. planned medical treatments or contact detail changes.

All information provided will be handled in the strictest of confidence. Thank you for your help!

General Information

Patient _____ _____
Surename, First Name — Date of Birth

Insured via _____ _____
☐ Spouse ☐ Parent — Date of Birth

Address _____
Street name, House number

_____
Postcode, town / City

_____
Contact numbers (Home / Mobile)

_____
E-Mail

Occupation _____

Health Insurance Provider _____

Current insurance status
☐ Compulsory Insurance ☐ Private Insurance
☐ Voluntary Insurance ☐ Aid Entiled
☐ private supplementary Insurance ☐ Uninsured

how did you find us?

☐ via the Internet
☐ via journals
☐ personal recommendation / who recommended us? _____
☐ other _____

General Health Questionnaire

Have you recently undergone any medical treatments through your GP or Hospital? ☐ yes ☐ no

Your GP: _____

Do you currently take any medication (Eg.: Marcumar, Aspirin, ASS etc.)? ☐ yes ☐ no
If yes, please detail: _____

Do you bleed abnormally long if injured? ☐ yes ☐ no

Are any unusual reactions known to medications such as e.g. odine or Penicillin? ☐ yes ☐ no
If yes, please detail: _____

Are there any known reactions to Dental injections? ☐ yes ☐ no
If yes, please detail: _____

Have you ever/are you currently undergoing any treatment for:

Allergies ☐ yes ☐ no
If yes,please detail: _____

Respiratory problems ☐ yes ☐ no
If yes,please detail: _____

Blood clotting problems ☐ yes ☐ no

Diabetes ☐ yes ☐ no

Epilepsy ☐ yes ☐ no

Glaucoma ☐ yes ☐ no

Hemic diseases (problems with blood producing organs) ☐ yes ☐ no

Cardiovascular diseases ☐ yes ☐ no

Chronic heart failure ☐ yes ☐ no

Coronary Heart disease / Angina Pectoris ☐ yes ☐ no

Heart attack ☐ yes ☐ no

Arrhythmia ☐ yes ☐ no

Cardiac pacemaker ☐ yes ☐ no

Valvular transplant/disease ☐ yes ☐ no

Hypertension (High blood pressure) ☐ yes ☐ no

Hypotension (Low blood pressure) ☐ yes ☐ no

Ametrohemia: ☐ yes ☐ no

Stroke ☐ yes ☐ no

Have you undergone any Operations? ☐ yes ☐ no
If yes, please detail: _____

Infectious diseases: ☐ yes ☐ no
- Hepatitis ☐ yes ☐ no
- HIV/AIDS ☐ yes ☐ no
- Tuberculosis ☐ yes ☐ no

Liver diseases ☐ yes ☐ no
If yes, please detail: _____

Gastrointestinal illnesses ☐ yes ☐ no

Kidney diseases ☐ yes ☐ no

Renal failure ☐ yes ☐ no

Dialysis ☐ yes ☐ no

Osteoporosis ☐ yes ☐ no

Rheumatism ☐ yes ☐ no

Hyperthyroidism ☐ yes ☐ no

Tumourous illnesses ☐ yes ☐ no

Do you smoke? ☐ yes ☐ no
If yes, how many per day? _____

Are you pregnant? ☐ yes ☐ no
If yes, which week? _____

Dental Health Questionnaire

What is your main reason for seeking treatment:

_____

Are you currently suffering from toothache?	☐ yes ☐ no
Do you have any problems with your gums?	☐ yes ☐ no
Do your gums bleed occasionally?	☐ yes ☐ no
Have you noticed any signs of bad breath?	☐ yes ☐ no
Do you have any tension or pain in your jaw area?	☐ yes ☐ no
Are you suffering from any chronic head, neck or shoulder pains?	☐ yes ☐ no
Do you gurn or grind your teeth?	☐ yes ☐ no
Are you frequently suffering from stress?	☐ yes ☐ no
Has your ability to chew been compromised?	☐ yes ☐ no
Are you happy with the look of your teeth?	☐ yes ☐ no
Are you currently using any dental hygiene products other than a toothbrush and toothpaste? If yes, please detail _____	☐ yes ☐ no
Have you undergone any X-rays in the last 12 months of the head, jaw or dental area?	☐ yes ☐ no
Do you suffer from any anxiety or phobia of dental treatments?	☐ yes ☐ no
Would you prefer a local anaesthetic?	☐ yes ☐ no

Would you like a specific consultancy about:

- ☐ Prevention of tooth decay
- ☐ A tooth friendly diet
- ☐ Permanent dental restauration
- ☐ Aesthetic improvements to your teeth
- ☐ Amalgam filling removal and replacement
- ☐ A lifetime of healthy teeth
- ☐ Gum health
- ☐ Implants
- ☐ Mandibular joint (jaw) diseases
- ☐ Other _____

The above information provided may be stored electronically, but underlies the strict rulings of data protection and patient confidentiality. By signing this document you agree that the information you have provided is correct and that you will advise us of any relevant changes as appropriate.

_____ _____

Date Signature

Reminder service for check-up appointments

☐ Yes, I agree that you may remind me of my next recommended appointment, to ensure that regular check-up's take place. This reminder service is free of charge and without obligation.

_____ _____

Date Signature