Medical History Questionnaire

Dr. Mehl

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Dear Ladies and Gentleman,

To ensure a complication free treatment and comply with official regulations we kindly ask you to share some valuable information with us. All submitted data will of course be treated confidentially and we adhere to governmental data protection policies. If you have troubles filling out the form we will always be happy to help and to assist you personally.

Thank you!

Personal data

Surname | Name | Date of birth

Street/House-Nr. | Postal code | City

Landline (private) | Landline (business) | Mobile

E-Mail @

Profession | Employer

Medical Anamnesis

1. Have you been in hospital in recent years or did you receive any medical treatment? Yes □ No □

   Name of your general practitioner_____

2. Are you taking any medication regularly at the moment?..... Yes □ No □
   If yes, what?_____

4. Important medication to mention to us:
   - Antidepressants (important if surgery is planned!)…….....…….…… Yes □ No □
   - Medication for Anticoagulation (e.g. Marcumar, Aspirin)…….....…….... Yes □ No □
   - Painkillers…….....……. Yes □ No □
   - Bisphosphonates due to osteoporosis in the last years..... Yes □ No □

5. Do you bleed longer than normal after injuries?..... Yes □ No □

Did you ever have:

6. Did you have any unusual reactions to injections or medication?..... Yes □ No □
   (e.g. iodine, penicillin etc.)?
7. Asthma, hay fever or other allergies?..... Yes □ No □
8. Heart or circulation diseases?..... Yes □ No □
   (e.g. Hyper-, Hypotonic, Endocarditic problems, replacement of the heart valves, infections)?
9. Rheumatic diseases or pain in the joints?..... Yes □ No □
10. Liver diseases?..... Yes □ No □
    (e.g. jaundice)?

11. Diabetes?..... Yes □ No □
12. Respiratory diseases?..... Yes □ No □
13. Kidney diseases?..... Yes □ No □
14. Infectious diseases?..... Yes □ No □
    (e.g. Tuberculosis, AIDS, HIV, Hepatitis, Gonorrhoea)?
15. Do you suffer from insomnia or snoring?..... Yes □ No □
16. Do you have problems with the thyroid?..... Yes □ No □
17. Epileptic seizures?..... Yes □ No □
18 Do you smoke?..... Yes □ No □
    If yes, how many per day?_____
19. Do you drink alcohol?..... Yes □ No □
    If yes, how many units a week (1 glass bier/wine is one unit)?_____
20. Do you take drugs?..... Yes □ No □
21. For female patients: Are you pregnant?..... Yes □ No □
    If yes, which week?_____
22. Do you have an artificial hip? Yes □ No □

Dental Anamnesis

1. Do you have problems with your teeth?..... Yes □ No □
   If yes, where?_____
2. Do you have problems with your gums?..... Yes □ No □
   If yes, where?_____
3. Is your chewing ability reduced?..... Yes □ No □
4. Do you like the look of your teeth or do you have aesthetical problems? Yes □ No □
   If yes, what?_____
5. Do you have TMJ problems of facial pain? ..... Yes □ No □
6. Do you have chronic head-, neck- or shoulder problems?..... Yes □ No □

The reason for your dental visit?

_____

Do you have any special wishes?

Dental hygiene □
Gum disease □
Root canal treatment □
Full mouth reconstruction □
Therapy of the TMJ □
Implants □
Aesthetics □
Halitosis (Bad breath) etc. □
Are you scared of the dentist? □

_____

How did you find us (e.g. word of mouth, google, bing, facebook, youtube, Instagram, other)

_____

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A few important information for you:

- *You must not drive when you had local injections and you are still numb.*
- *To keep your teeth healthy in the long run, we would like to inform you about your regular check-ups and dental hygiene.*
- ***How would you like to be reminded***
  SMS ☐ ***Email*** ☐ ***Call*** ☐
- ***Since we reserve the times especially for you we would like to ask you if you have something important coming up to cancel your appointment more than 24 hours before the time of the appointment. If you can't manage to cancel in that time period we will have to charge you 75 GBP per half hour.***
- ***The SMS reminder is a service from our clinic. In case you want to cancel your appointment, please call us.***
- *If your personal data and your medical status change we would like to ask you to inform us immediately.*
- *I assure that the given information is correct. I agree that my personal data, e.g. x-rays and photographs and their respective copies can be used for scientific purposes, and can be forwarded to medical colleagues, insurances and debt collections services.*

With your signature you verify that the data you have given are true to your best knowledge and that you are happy with the statement above.

London, the (Date) Signature

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