

Dr. Udo Dehling
Zahnarzt

Bahnhofstraße 11b

90402 Nürnberg

☎ 0911 / 44 56 56

www.zahnarztpraxis-dr-dehling.de

info@zahnarztpraxis-dr-dehling.de

Patient questionnaire

Dear patient

welcome to our dental office!

Please complete this questionnaire in order to ensure best possible dental treatment and care.

All informations will be treated as confidential!

Patient

last name

first name

birthday

Address

street and number

city and country

Phone

privat

selfphone

at work

E-Mail Address

Insurance

compulsory insurance/pflicht-versichert

voluntary insurance/ freiwillig- versichert

private insurance /privat versichert

Supplementary insurance /Zusatzvers.

yes

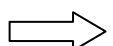
no

if yes, at which company/ wenn ja, bei welcher Gesellschaft

Occupation/ Beruf

Employer / Arbeitgeber

next page



Do any of these health problems or risk factors apply to you?

Are you in consent strictly?/ Sind Sie in dauernder ärztlicher Behandlung?

Yes No

If so, why? / Wenn ja, warum? _____

Name and address of your family doctor: _____

1. **Valvular heart defect /** Herzklappenerkrankung

Yes No

Arrhythmia / Herzrhythmusstörung

Yes No

Do you have a cardiac Pacemaker/defibrillation Implantat?

Yes No

Herzschrittmacher-/ Defibrillator- Implantation?

2. **Hypertension /** Erhöhter Blutdruck

Yes No

Hypotension / Zu niedriger Blutdruck

Yes No

3. **Hemopathy or hemorrhage/**

Yes No

Bluterkrankungen oder verstärkte Blutungsneigung

Do you take coagulation inhibitors?/

Yes No

Nehmen Sie gerinnungshemmende Medikamente?

4. **Infection diseases? /** Infektionserkrankungen

Tuberculosis / Tuberkulose

Yes No

Jaundice, Hepatitis/ Gelbsucht, Hepatitis

Yes No

5. **Diabetes mellitus,** Zuckerkrankheit (Diabetes)

Yes No

Insulin required / Insulinpflichtig

Yes No

Thyroid malfunctions / Schilddrüsenerkrankungen

Yes No

Organic diseases for example Kidney/

Yes No

Erkrankung der inneren Organe z.B. Niere

6. **Nerve diseases for example epilepsy/** Nervenleiden z.B. Epilepsie

Yes No

Depression/ Depressionen

Yes No

Are you addicted to alcohol?/ Sind Sie alkoholabhängig?

Yes No

7. **Allergies, hypersensitivity reactions/** Allergien?

Yes No

If so, which?/ Wenn ja, welche? _____

8. **Are you HIV positive? Sind Sie HIV positiv?**

Yes No

9. **When have you been tested to HIV ?** Wann wurden Sie getestet? _____

10. **Any other health problems not mentioned so far? If so which?** _____

Bestehen sonstige Erkrankungen, welche bis jetzt nicht aufgeführt wurden, wenn ja welche?

11. **Do you take any medicine, if so which?/** Nehmen Sie Medikamente ein, wenn ja, welche?

12. **Autoimmune diseases (for example rheumatism) If so, which?** Autoimmunerkrankung z.B. Rheuma

14. **For females: Are you pregnant? if yes, which week?** _____

Sind Sie schwanger? Wenn ja, in welchem Monat?

Please keep us informed of any changes in your address, state of health, medication, and – in case of female patients-of possible pregnancy!

Narcotics (pills or injections) limit your ability to respond. Therefore, you should not operate any machine and do not participate in traffic when narcotics were administered, or you have taken appropriate tablets. Please consider this when treatment appointments.

Yours **Dr. Udo Dehling**

Date: _____

Signature: _____