Praxisklinik Kaarst

Dr ■ med ■ Dr ■ med ■ dent ■ Thorsten Ruschhaupt

Oral, orthodontic, and facial surgeon
Outpatient operations

Medical History – Questionnaire

This medical history questionnaire helps us to determine whether there are any notable disorders which could affect your treatment. Please assist us by taking the time to fill out this medical history questionnaire carefully.

Not sure? If you have any questions, please feel free to ask us or the physician treating you.

Privacy. All questions and answers are treated as confidential and are subject to the statutory safeguards against the disclosure of doctor-patient communications.

Current information. Please inform us immediately of any new disorders or changes in your medication that may occur during the course of your treatment.

Personal data

Last name, first name

Date of birth

Date of birth

Street address

Postal code and city

Phone (land line)

Work phone

Cell phone

Email

Occupation, employer

Dentist treating you

Your family physician

Insurance

☐ Statutory coverage ☐ Private coverage ☐ Additional coverage

☐ Basic rate ☐ Eligible for benefits

If the patient and the policyholder are not the same person, please enter the policyholder's details.

Last name, first name

Date of birth

Street address

Postal code and city

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General situation

Yes	No		
☐	☐	Are you currently being treated by a doctor (not a dentist)?	
☐	☐	Have you been hospitalized recently (within the last year)?	If yes, for what?
☐	☐	Do you have any allergies (allergy pass card)?	If yes, against what?
☐	☐	Do you have a cardiac pacemaker or prosthetic heart valve?	
☐	☐	Do you have cardiac insufficiency or an irregular heartbeat (arrhythmia)?	
☐	☐	Do you suffer from angina pectoris or have you had a heart attack?	
☐	☐	Do you have a stent (mechanical expander within the coronary arteries)?	If yes, since when?
☐	☐	Do you suffer from high or low blood pressure?	High ☐ Low ☐
☐	☐	Do you suffer from a bleeding disorder?	
☐	☐	Are you taking any blood-thinning medications (such as aspirin (acetylsalicylic acid), Marcumar, heparin, Fragmin, Clexane, Iscover, Plavix, Efient, Eliquis, Pradaxa, Xarelto)?	If yes, which?
☐	☐	Do you suffer from asthma or shortness of breath?	
☐	☐	Do you suffer from diabetes?	How are you blood sugar values?
☐	☐	Do you have any neurologic disorders (seizures, stroke, Parkinson's disease)?	

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Yes	No		
☐	☐	Do you have an eye disorder (such as angle closure glaucoma)?	
☐	☐	Have you ever had a liver disorder (jaundice, hepatitis)?	
☐	☐	Do you suffer from any gastrointestinal disorders?	
☐	☐	Have you had a kidney disorder or do you require dialysis?	
☐	☐	Do you have any infectious diseases such as hepatitis, HIV, or tuberculosis?	If yes, which?
☐	☐	Do you have hyperthyroidism or hypothyroidism?	If yes, which?
☐	☐	Are you taking medications for osteoporosis, bone pain, or bone metastases (such as alendronate, Fosamax, Fosavance, Bonefos, Clodron, Ostac, Elidronat, Bonviva, pamidronate, Ribrodonat, Actonel, Zometa, Denusomab)?	If yes, tablet or injection?
☐	☐	Do you suffer from a rheumatic disorder?	
☐	☐	Do you suffer from an immune disorder?	
☐	☐	Are you pregnant?	
☐	☐	Are you, or have you been, addicted to any drugs?	
☐	☐	Do you smoke?	If yes, how much?
☐	☐	Do you drink alcohol regularly?	If yes, how much?

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General situation

Which disorders are known and what would you like to mention in particular?

Which medications do you take regularly?

Contact:
Tel: 0 21 31 66 04 44
Fax: 0 21 31 66 04 41
info@praxisklinik-kaarst.de
www.praxisklinik-kaarst.de

I understand that I will be unable to operate any motor vehicle after a surgical procedure.

Date

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Signature

Print Send Mail