DR. HELMUT
STEINER
ZAHNARZT

DR.DR.CHRISTOPH
STEINER
FACHARZT FÜR MUND-,
KIEFER-, GESICHTSCHIRURGIE
ZAHNARZT
MSC KIEFERORTHOPÄDIE

Health History Form

Dear Madam or Sir!
Please answer the following questions thoroughly, they are vital to allow us to provide appropriate care for you. Your answers are for our records only and will be kept confidential. If you have any question, do not hesitate to ask us.

Yes	No	
○	○	Are you currently being treated by a physician? If so, what is/are the condition(s) being treated?
		Women:
○	○	Are you or could you be pregnant? If yes, in which month? _____
○	○	Nursing?
○	○	Do you take birth control pills?
		Do you or did you have any of the following diseases / problems:
○	○	• Allergies (e.g. latex, iodine, chromium, nickel, antibiotics-penicillin). Which? _____
○	○	• Drug sensibilities. Which? _____
○	○	• Epilepsy / seizures
○	○	• Dizziness / fainting
○	○	• Diabetes mellitus
○	○	- Insulin-dependent?

Yes	No	
○	○	• Respiratory diseases. Which? _____
○	○	- Asthma, chronic obstructive pulmonary disease (COPD)
○	○	• Glaucoma
○	○	• Cardiovascular diseases
○	○	- Heart failure
○	○	- Coronary heart disease / angina pectoris / chest pain during exercise / shortness of breath
○	○	- Heart attack
○	○	- Bypass operation / Stent
○	○	- Irregularity of pulse / arrythmia
○	○	- Pacemaker
○	○	- Valvular defect / prosthetic heart valve
○	○	- Endocarditis
○	○	- High blood pressure
○	○	- Low blood pressure / circulatory collapse
○	○	- Apoplectic stroke
○	○	• Infectious diseases
○	○	- Hepatitis (jaundice) A/B/C
○	○	- HIV / AIDS. If yes, since when? _____
○	○	- Tuberculosis
○	○	- Sexually transmitted diseases. Which? _____
○	○	• Liver diseases. Which? _____
○	○	• Stomach troubles / bowel disease / ulcers
○	○	• Kidney problems / kidney insufficiency / dialysis / transplantation
○	○	• Neurological disorders. Which? _____
○	○	• Mental health disorders / depression
○	○	• Osteoporosis

Yes	No	
○	○	• Rheumatoid arthritis / rheumatic disease
○	○	• Thyroid disease / overactivity (hyperthyroidism)
○	○	• Cancer. Which? _____
○	○	• Further diseases: _____
○	○	Do you take any drugs or medications? Please list completely:
○	○	Have you had any complications following injections or the intake of medications?
○	○	Prolonged bleeding? (bleeding tendency, hemophilia)
○	○	Do you take blood thinners (e.g. cumarins, aspirin)?
○	○	Have you had any operation? Which? _____
○	○	Do you smoke? If yes, how many packs per day? _____
○	○	Do you feel discomfort when chewing?
○	○	Do you have pain when opening your mouth fully or when yawning?
○	○	Do you hear clicking or grinding sounds in your temporomandibular joint?
○	○	Do you have headaches frequently?
○	○	Do you have lower neck aches or backaches?
○	○	Do you have a dry mouth?
○	○	Do you have a burning mouth?
○	○	Did you ever have a maxillary or frontal sinusitis?
○	○	Did you ever have oral or maxillofacial surgery?

_____ _____

Date Signature of patient or legal guardian