25.06.2021

8. Anhang 8.01. Formulare	**Health Questionnaire**	**8.01.13** Version 06

Last name:_____ **First name:**_____ **Date of birth:**_____

*Address:*_____ *Phone/mobile:*_____

Health insurance: _____ *E-mail:*_____

Family doctor: _____ *Family dentist:* _____ *Custodian for health:* _____

Welcome to the Department of Orthodontics. This questionnaire is subject to medical confidentiality. In the interest of a complication-free treatment please fill it in correctly. If you cannot or do not wish to answer particular questions, please talk about it with your dentist **before** treatment.

1.	Do you think your general well-being is currently affected by your teeth?	O Yes	O No
2.	Are you unhappy with the appearance of your teeth?	O Yes	O No
3.	Does the thought of an upcoming dental treatment make you feel uncomfortable?	O Yes	O No
4.	Do you have difficulties in chewing or opening your mouth widely?	O Yes	O No
5.	Do you have sensitive teeth, bleeding gums or any other gum problems?	O Yes	O No
6.	Do you often suffer from toothaches?	O Yes	O No
7.	Have you ever had an accident involving injuries to the face, jaw or teeth?	O Yes	O No
8.	Do you suffer from any diseases of the sinuses (such as sinusitis)?	O Yes	O No
9.	Did you ever experience painful swellings of your joints?	O Yes	O No
10.	Are you allergic to certain medications or substances (e.g. nickel, pollen)?	O Yes	O No
11.	Do you have an allergy card?	O Yes	O No
12.	Are you pregnant?	O Yes	O No
13.	Has your health condition changed in recent years?	O Yes	O No
14.	Has your appetite or your weight changed recently?	O Yes	O No
15.	Are you currently receiving medical treatment?	O Yes	O No
16.	Have you ever had surgery?	O Yes	O No
17.	Have you ever been seriously ill?	O Yes	O No
18.	Have you ever been treated for cancer or any other tumor?	O Yes	O No
19.	Did you ever undergo radiotherapy?	O Yes	O No
20.	Are you currently taking medication or have you taken any medication within the last six months? (prescription or non-prescription?) If yes, please specify: _____ _____	O Yes	O No
21.	Do you regularly take drugs?	O Yes	O No
22.	Are you currently suffering from German measles, mumps, measles or scarlet fever?	O Yes	O No
23.	Have you ever suffered or are you currently suffering from any of the following diseases?		
	Heart (e.g. heart attack, myocarditis)	O Yes	O No
	Circulation (e.g. high blood pressure, circulatory disorder, stroke)	O Yes	O No
	Respiratory tract/lungs (e.g. asthma, bronchitis)	O Yes	O No
	Digestive tract, kidneys, bladder	O Yes	O No
	Liver (e.g. icterus)	O Yes	O No
	Motion apparatus (e.g. rheumatism, arthritis)	O Yes	O No
	Central nervous system (e.g. epileptical attack)	O Yes	O No
	Autonomic nervous system (e.g. headaches, migraine)	O Yes	O No
	Metabolism (e.g. diabetes, gout)	O Yes	O No
	Thyroid gland (e.g. hyper-or hypoactivity)	O Yes	O No
	Diseases of the blood-forming system (e.g. anaemia, haemophilia)	O Yes	O No
	Tuberculosis	O Yes	O No
	Hepatitis	O Yes	O No
	HIV (AIDS)	O Yes	O No
	Skin diseases	O Yes	O No
	Sexually transmitted diseases (STDs)	O Yes	O No
	Diseases of the eyes (e.g. cataract, glaucoma)	O Yes	O No
	Do you suffer from any disease, condition or problem not previously listed?	O Yes	O No
	If yes, please specify: _____ _____		
24.	Do you play any musical instruments? If yes, which one?_____If yes, how often?_____	O Yes	O No

Furthermore I was informed, that I have to report any changes in my physical, dental or general health condition immediately.

Hamburg, _____ Signature: _____