

Health Questionnaire

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

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

Hamburg, _____ Signature: _____