

Patient Survey

Last Name, First Name:

Address:

DoB: Place of Birth : Profession:

Mobile: Landline:

Email: Main Dentist (Name):

Please answer the following questions regarding your state of health as accurately as possible! This data is subject to doctor-patient confidentiality and GDPR, and will be treated with utmost confidentiality.

Cardiovascular Diseases:

High blood pressure yes no

Heart valve defects/replacements yes no

Pacemaker yes no

Endocarditis yes no

Heart surgery yes no

Tumour diseases yes no

Gastrointestinal diseases yes no

Organ transplant yes no

Other diseases: yes no

Which:.....

Infectious diseases:

HIV Infection, AIDS yes no

Liver diseases/Hepatitis yes no

Tuberculosis yes no

Other infectious diseases yes no

Which:

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Epilepsy

yes no

Neurological disorder yes no

Asthma/ lung diseases yes no

Blood-clotting disorder (secondary haemorrhage) yes no

Diabetes yes no

Kidney diseases yes no

Osteoporosis yes no

Rheumatism/Arthritis yes no

Thyroid diseases yes no

Smoker yes no

Drug addiction yes no

Allergies (or intolerances):

allergy passport (where available)

Localised anaesthetic yes no

Antibiotics yes no

Painkillers yes no

Other:

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Have dental X-rays already been taken of you (X-ray registration card)?

If so, when?

Which medication do you take regularly/currently?:

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Do you have intolerances against certain medication?:

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Are you taking/ have you taken bisphosphonates? yes no since

Are you undergoing chemotherapy? yes no since

Are you undergoing radiotherapy as cancer treatment? yes no since

Are you taking high dosage steroid /immunosuppressants? yes no since

Have you had major operations

done in a hospital setting? yes no since:

Which:

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For our biologically female patients:

Are you pregnant? yes no

If so, how many months along?months

I agree to the electronic storage, processing and usage of my data as well as the transfer of X-rays via data transfer should the images be requested by other doctors.

This consent may be withdrawn in writing at any time

I will immediately declare any changes to the above that may occur while in treatment.

Furthermore, I will keep treatment appointments or alternatively cancel the appointment at least 24hrs prior to the appointment time

Please note that you are not permitted to operate a vehicle following a procedure using local anaesthetics!

.....,dateSignature: