dr. stefan mürbeth
zahnarzt

MEDICAL HISTORY FORM

Dear patient!

We are looking forward to have the privilege of welcoming you to our practice. To make your visit as pleasant as possible, we need your help. Please fill out this form carefully so that we can do our best to meet your needs. All information is of course subject to medical confidentiality.

PERSONAL INFO

Last name, first name	Date of birth	Place of birth
Street	Postal code, city	
Phone number (land line)	Phone number (work)	Phone number (mobile) ☐ Texts
E-mail adress	Occupation, employer	**Appointment reminder**

INSURANCE

Health insurance

If the patient and the person with insurance are not the same, please provide the information of the policyholder:

Last name, first name	Date of birth	place of birth
Street	Postal Code, City	

HOW DID YOU HEAR ABOUT OUR PRACTICE?

Recommendation by:

Referral by:

☐ Office sign ☐ Internet ☐ Yellow pages ☐ _____ other

TURN PAGE

An den Gärten 1, 92665 Altenstadt | 09602 - 636 663 | info@altenstadt-zahnarzt.de | **www.altenstadt-zahnarzt.de**

DENTAL HISTORY

Please tick or fill out as appropriate.

What is your reason for visiting us? ☐

_____

Main concern

Have you ever had issues during dental treatments? ☐

_____

If so, which ones?

Do you have sensitive teeth or tooth necks? ☐

Are you suffering/have you suffered from a maxillary sinus illness? ☐

Do your gums bleeding? ☐

Are your gums receding? ☐

Are your teeth loose? ☐

Tooth loss or loosening teeth? ☐

Tooth migration? ☐

Inflammation with swollen gums? ☐

Any previous gum treatment? ☐

_____

If so, when?

Do you suffer from bad breath? ☐

Have your teeth been X-rayed within the past 12 months? ☐

If we need to request these X-ray images for you, we require the address of your previous dentist: ☐

_____

Previous dentist

_____

Adress

Do you wear removable dentures? ☐

_____

In the upper jaw (years)

_____

In the lower jaw (years)

Do you have extreme dental phobia? ☐

Do you feel affected by discolored teeth? ☐

Have you ever tried to whiten your teeth by yourself? ☐

Would you like whiter teeth? ☐

CRANIOMANDIBULAR DYSFUNCTION/CMD

The purpose of this questionnaire is to determine the effects of functional disorders of the masticatory system (CMD, craniomandibular dysfunction). If you answer multiple questions with “yes”, we will clarify whether further diagnosis is necessary as part of a medical consultation. **Please tick or fill out as appropriate.**

Have you ever been in an accident that damaged your neck/head area? ☐

Do you suffer from headaches or migraines? ☐

Do you have tension in your neck/shoulder muscles? ☐

Do you have chronic back pain? ☐

Do you have disturbance of equilibrium or dizziness? ☐

Do you feel like something is wrong with your bite? ☐

Do you grind or clench your teeth? ☐

Do you suffer from sleep disorders (snoring, sleep apnea)? ☐

Do you occasionally or constantly feel like you are exposed to stress in your professional or private life? ☐

Have you received/are you receiving orthodontic treatment? ☐

Do you have issues with your crowns/ your current dentures? ☐

_____

If so, which ones?

Are you currently undergoing physiotherapy/ osteopathic treatment? ☐

Do you chew a lot of gum? ☐

TURN PAGE

MEDICAL HISTORY

Please tick or fill out as appropriate.

Heart disease/cardiovascular disease? (E.g., heart defects, angina pectoris, heart attack, heart muscle inflammation, endocarditis, artificial heart valve, pacemaker, high blood pressure, low blood pressure, arrhythmia, heart failure) ☐

Vascular disease? (E.g., stroke, circulatory disorders, varicose veins, thrombosis) ☐

Respiratory/lung disease? (e.g., asthma, pneumonia, tuberculosis, chronic bronchitis) ☐

Liver disease? (e.g., jaundice, cirrhosis, fatty liver disease, gallstones, hepatitis) ☐

Stomach/bowel disease? (e.g., ulcers, heartburn, reflux disease) ☐

Eye disease? (e.g., cataracts, severe vision impairment, blindness) ☐

Blood disorder? (e.g., coagulation disorders suffered by yourself or by blood relatives, frequent nose bleeds, bruises after the slightest touch, postoperative bleeding) ☐

Immunodeficiency? (e.g., taking cortisone, organ transplantation, HIV positive/AIDS) ☐

Allergies? (e.g., medicine, bandages, latex) If you have one, please take your allergy pass with you! Which ones? ☐

Have you been or are you currently being treated with bisphosphonates? (For what disease? For how long? With what preparation?) ☐

Other diseases or disorders? (e.g., cancer) ☐

Do you smoke? How much on average? ☐

Do you take anticoagulant drugs? (e.g., Aspirin®, Marcumar®) ☐

Do you take medication on a regular basis? Which ones? ☐

Do you take contraceptives (birth control pill)? ☐

Are you pregnant? If so, how many weeks have you been pregnant? ☐

CO-THERAPISTS

Please provide the name and practice/clinic address.

My general practitioner is

My current attending specialists are

I have understood this medical history form and have answered the questions correctly.

Altenstadt, date Signature

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