Health Questionnaire

The following personal information will help our practice to give you the best possible personal treatment.This information will be handled with the utmost discretion as required by the medical Code of Ethics.

Patient:

____
Name

____
First name

____
Street

____
City

____
Date of birth

____
Phone

____
Family doctor

In health insurance with:

____
Name

____
First name

____
Street

____
City

____
Date of birth

____
Phone

____
Recommended by

kind of health insurance:

O legal health insurance
O optional insurance
O private health insurance
O additional insurance
O allowance (deductible???) …….%

____
Name of your health insurance

Have you had or do you have any of the following?

Heart disease:
O Heart weakness
O Arrhythmia
O Angina pectoris
O cardiac pacemaker
O phase after heart collapse

Circulatory disorders:
O high blood pressure
O low blood pressure

Infectious Disease
O Hepatitis (A, B, C)
O Tuberculosis
O HIV/AIDS
O hepatic disease
O rheumatic fever

Allergic reactions:
O Eczema
O Penicillin
O Asthma
O do you have an allergy passport?
O Hypersensitivity to any medications?

Diseases of the eyes:
O higher eye pressure inside?

Metabolic disease:
O Diabetes
O Gastrointestinal Disease
O Thyroid disease

Blood Diseases:
O Anemia
O blood coagulation disorder

Neurological Disease:
O Apoplexy
O Epilepsy (clenching)

Diseases of organs: ?????????
O renal disease

O Sinusitis

jaw joint:
O any noises, cracking?
O any pain?

Gums:
O bleeding?
O recession?

Any other diseases:
O__________________ …………………………..

Any medications?
O no O yes
………………………………………..

Pregnant? O no
O If yes, due date ……..

USH, ___________________ ______________________________________
Date **Signature**