Medical History

Versicherungsanstalt
öffentlich Bediensteter, Eisenbahnen und Bergbau

Dear patient!

In your own interest, we kindly ask that you diligently complete the following questions before your treatment so that we can address your individual needs. If you need help filling out the form or have any questions, our staff will, of course, be at your disposal!

A current and complete medication list must be brought along to each appointment!

Personal data:

Name: .....
Address: .....
.....
Tel: .....
Email: .....
General practitioner: .....
.....

Insured person: .....
Health insurance / self-payer: .....
Social insurance number: .....
Date of birth: .....
Additional dental insurance: .....
How did you hear about us?
.....

Health questionnaire:

1) Are you taking any medications? **YES** ☐ **NO** ☐
If yes, which ones?
.....

2) Do you receive injections regularly? **YES** ☐ **NO** ☐
If yes, which ones?
.....

3) Do you suffer from any allergy / drug intolerance? **YES** ☐ **NO** ☐
If yes, which?
.....

4) Do you suffer or have you suffered from any of the following infectious diseases?
(Hepatitis A, B, C, Tuberculosis, HIV/ AIDS or other) **YES** ☐ **NO** ☐
If yes, which?
.....

5) Do you suffer or have you suffered from diabetes mellitus/diabetes? **YES** ☐ **NO** ☐

6) Do you suffer or have you suffered from osteoporosis? **YES** ☐ **NO** ☐

7) Are you or could you be pregnant? **YES** ☐ **NO** ☐

8) Are you currently breastfeeding? **YES** ☐ **NO** ☐

9) Do you suffer or have you suffered from epilepsy? **YES** ☐ **NO** ☐

10) Do you have a congenital bleeding tendency (frequent bruising and/or nosebleeds) or do you take blood-thinning medications? **YES** ☐ **NO** ☐
If yes, which one?
.....

Please turn over!

11) Do you suffer or have you suffered from any respiratory disease? (e.g., asthma, COPD) **YES ☐ NO ☐**
If yes, which one?
.....

12) Do you smoke? **YES ☐ NO ☐**
If yes, how much per day? ....

13) Do you have a disease of the cardiovascular system? (e.g., valve replacement, hypertension, dysrhythmia, heart attack, angina, heart failure, tendency to faint) **YES ☐ NO ☐**
If yes, which ones?
.....

14) Do you wear a pacemaker? **YES ☐ NO ☐**

15) Do you have a disease of the eyes (e.g. glaucoma, glaucoma)? **YES ☐ NO ☐**
If yes, which ones?
.....

16) Do you have a disease of the thyroid gland? **YES ☐ NO ☐**
If yes, which?
.....

17) Do you have a disease of the kidneys? **YES ☐ NO ☐**
If yes, which?
.....

18) Do you have any disease affecting the digestive organs? **YES ☐ NO ☐**
If yes, which ones?
.....

19) Do you have / have you had a tumour/ chemotherapy or radiation therapy? **YES ☐ NO ☐**
If yes, which?
.....

20) Have you had any recent surgery? **YES ☐ NO ☐**
If yes, which?
.....

21) Do you suffer from any autoimmune disease? **YES ☐ NO ☐**
If yes, which ones?
.....

22) Do you have an immune deficiency? **YES ☐ NO ☐**

23) Do you suffer from a nervous system disorder or mental illness? **YES ☐ NO ☐**
If yes, which?
.....

24) Have you had a stroke in the past year? **YES ☐ NO ☐**

25) Why are you seeing us today?

☐ Pain/swelling bleeding ☐ Check-up ☐ Denture/prosthesis problems

☐ gums Other:..... ☐ Tooth or filling fracture ☐ Consult/ second opinion

26) When was your last dental check-up? .....

27) Do you experience bleeding gums? (e.g., when brushing your teeth) **YES ☐ NO ☐**

I understand that I must disclose any change in my personal or medical information as soon as possible. This is the only way we can ensure the best possible treatment and care! If you are unable to keep your appointment, please notify us at least 24 hours in advance!

Place/date: Signature of patient / legal guardian: