Universitäres Zentrum für Zahnmedizin Basel UZB
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Universitäres Zentrum
für Zahnmedizin Basel

Questionnaire

Medical problems and medication can have an effect on dental treatment. It is important to therefore fill in this questionnaire. This information will be treated with the strictest confidence and is legally protected by medical confidentiality.

Patient ○ Ms ○ Mr

Name _____
Forename _____
Street & Nr. _____
Postcode, Town _____
Date of birth _____

E-Mail _____
Tel. private _____
Tel. business _____
Tel. mobile _____
Nationality _____
Employment _____

Insurance ○ Medical: _____ ○ Dental cover _____ ○ Accident: _____
Nr. _____

Do you receive benefits? ○ Income support (Ergänzungsleistung) ○ Social benefits (Sozialhilfe) ○ No benefits

Legal guardian if under 18

○ Ms ○ Mr

Name, forename _____
Street & Nr. _____
Postcode, Town _____

Tel. private _____
Tel. business _____
Tel. mobile _____

○ **Family Doctor** ○ **Treating doctor** ○ **Paediatrician**

○ Frau ○ Herr

Name, forename _____
Street & Nr. _____

Postcode, Town _____
Tel. surgery _____
Tel. mobile _____

Private dentist

○ Frau ○ Herr

Name, forename _____
Street & Nr. _____

Postcode, Town _____
Tel. surgery _____
Tel. mobile. _____

Reason for visit: _____

Referring doctor or dentist

Name, forename _____
Street & Nr. _____
Postcode, Town _____

Health Questionnaire

01. Have you been or are you under treatment from a doctor? ○ Yes ○ No
If yes, for which **illnesses**? _____

02. Have you had any **operations**? If yes, what? _____ ○ Yes ○ No

03. Do you have or have you had **hepatitis** (jaundice, liver disease)? ○ Yes ○ No

04. Do you regularly take **medication?** If yes, which? ○ Yes ○ No

_____

_____

Do you take Bisphosphonate? (e.g. for osteoporosis) ○ Yes ○ No

05. Do you suffer from any **cardio-vascular disease**? ○ Yes ○ No

○ Low or high blood pressure Value: ○ Angina pectoris
○ Heart attack ○ Stroke
○ Heart valve defect, artificial heart valve ○ Heart inflammation (endocarditis)

06. Are you **HIV positive?** ○ Yes ○ No

07. Do you suffer from any **blood disorder?** ○ Yes ○ No

○ Blood diseases (e.g. Haemophilia) ○ Iron deficiency (Anaemia)

Are you taking **anticoagulants** (blood thinning) medication? ○ Yes ○ No

08. Do you suffer from any **metabolic disease?** ○ Yes ○ No

○ Over or underactive thyroid ○ Diabetes
○ Other: _____

09. Do you have **allergies**? ○ Yes ○ No

○ Hay fever ○ Asthma ○ Other: _____

Do you have an allergic reaction to:

○ Injections ○ Medicine
○ Mouth wash ○ Foods

10. Have you ever had:

○ Maxillary sinusitis ○ Chemotherapy? Why? _____
○ Arthritis or joint swelling?
○ Digestive problems? ○ Radiotherapy? Where? _____
○ Hormone problems? ○ Other serious illnesses?
○ Tuberculosis? If yes, what?
○ Disease of lungs, liver, kidneys or other organs? _____

11. Are you **pregnant**? How many weeks? _____ ○ Yes ○ No

12. Do you have any **artificial joints**, a **pacemaker** or any other **implant**? ○ Yes ○ No

What? _____

13. Are you a smoker or have you smoked? What? _____ How many? _____ ○ Yes ○ No

14. Do you have bad **breath**? ○ Yes ○ No

15. Do you wear a **gum shield** for sport? ○ Yes ○ No

Have you recently had an **accident** involving your teeth**?** ○ Yes ○ No

I **understand** that the data or information from my medical history, including x-ray pictures and photos, or copies or printouts thereof can be forwarded for the purpose of clarification or information to third parties (e.g. doctor, insurers or others bound by medical confidentiality). I also **agree** that data necessary for invoicing, accounting and debt collecting can be given to the relevant authorities.

Date: Signature:

I **consent** to being given local anaesthesia if necessary. I have been informed that this can in very rare cases result in side effects (continuing feeling of numbness, tingling sensation) in the lower jaw or tongue, which is usually temporary. I understand that following oral surgery procedures under local anaesthesia it is not advisable to drive or cycle for several hours.

Date: Signature:

I **consent** to that all data relating to me, biopsies and extracted teeth being used for medical research purposes in an anonymous form and with strict confidentiality. Data can under strict confidentiality be examined and controlled by the relevant authorities and the kantonal ethics commission. With regard to this the dentists who undertook the treatment are cleared of liability. I can at any time retract this consent (Vetorecht) without it negatively affecting me.

Date: Signature: