Dental Team Lucerne – Practice Dr. Schulte
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Registration for Treatment

We kindly ask you to fill out this health questionnaire. Your information will be kept confidential.

Name: ______ Last Name: ______
Street: ______ ZIP / City: ______
Date of Birth: ______ Occupation: ______
Home Phone: ______ Work Phone: ______
Fax: ______
Cell Phone: ______ E-Mail: ______ @ ______
Guardian / Correspondence Address: ______
May we send your correspondence (recall letters / bills / cost estimates) via E-mail? ☐ yes ☐ no
Shall we send you a reminder the day before your appointment ☐ yes, per email yes, per SMS ☐ no

Do you receive support from social services? ☐ yes ☐ no
Were you referred to us? By whom?: ______
Are you in pain or have a specific problem with your teeth at this time? ☐ yes ☐ no
Are you afraid of dental treatment? ☐ yes, very much / always ☐ yes, moderately ☐ no, never
Have you ever experienced dizziness or fainting during dental treatment? ☐ yes ☐ no

Are you under medical care at this time? ☐ yes ☐ no
If yes, why? ______
Family doctor or specialist (name / city) ______
Have you been treated in hospital during the last two years? ☐ yes ☐ no
If yes, for what illness or operation? ______
Are you currently taking any medications? ☐ yes ☐ no
If yes, please list name and dosage ______
Are you pregnant? (if yes, which month? ______) ☐ yes ☐ no
Do you smoke (If yes, how many per day ______)? ☐ yes ☐ no

Do you have or have you had one of the following conditions?

Cardiocirculatory conditions

Heart Attack? (If yes, when?______) ☐ yes ☐ no
Angina Pectoris, Coronary Artery Disease? ☐ yes ☐ no
Cardiac Insufficiency? ☐ yes ☐ no
Cardiac Rhythm Disturbances? ☐ yes ☐ no
Valve Prosthesis? ☐ yes ☐ no
Pace Maker? ☐ yes ☐ no
Heart Defect (eg mitral valve prolapse) ☐ yes ☐ no
Other Heart Conditions? (If yes, what ______) ☐ yes ☐ no
High Blood Pressure (Hypertension) ☐ yes ☐ no

Please fill out also the second page of the questionnaire

Bone diseases

Do you suffer from osteoporosis? ☐ yes ☐ no

If yes, which specific medication are you taking? ______________________

Blood Disorders

Do you have a tendency towards bleeding? ☐ yes ☐ no

Do you have a clotting disorder (If yes, which__________________________) ☐ yes ☐ no

Do you take blood thinners (If yes, which _______________________) ☐ yes ☐ no

Have you ever had extensive bleeding (hemorrhage) after dental treatment? ☐ yes ☐ no

Allergies:

Are you sensitive to any specific medications or materials? ☐ yes ☐ no

Which? ____

Do you suffer from asthma or hay fever ? ☐ yes ☐ no

Infective Diseases:

HIV / AIDS ☐ yes ☐ no

Hepatitis A ☐ / B ☐ / C ☐ ☐ yes ☐ no

If yes, when were you diagnosed? _____________

Other Illnesses

Diabetes ☐ yes ☐ no

If yes, Do you take insulin? ☐ yes ☐ no

Epilepsy, Convulsions ☐ yes ☐ no

Tumors (cancer, leukemia) ☐ yes ☐ no

If yes, which, diagnosed when ? ____

Have you had radiation therapy of the jaw-neck-facial area? ☐ yes ☐ no

Other disorders not listed above ☐ yes ☐ no

Which ____

If anything should change in your health status, please notify us at your next appointment.

Please take care when leaving your dental appointment, your reaction time may be slowed. After receiving general anaesthesia or any kind of conscious sedation, you are not allowed to drive for 12 hours.

Date:________________________ Signature:______________________________________

Signature of Parent / Guardian ___________________________________