Specialist in Oral and Maxillofacial Surgery Dr. Dr. Dirk Baumann

Name, First name: _____ Date of birth.: _____ **Phone.:** _____

Full address: _____

Dentist: _____ Health insurance: _____

Policyholder: _____ Date of birth: _____

Adress, if different: _____

Profession: _____

Dear patient,

The answers to the following questions are of great importance for your treatment.

	Yes	No
Do you have high blood pressure?	☐	☐
Do you have low blood pressure?	☐	☐
Do you or did you have any heart diseases?	☐	☐
If yes:		
Congenital or acquired heart defects	☐	☐
Heart valve defect or valvular prosthesis	☐	☐
Endocarditis	☐	☐
Heart surgery	☐	☐
Cardiac pacemaker	☐	☐

Other_____

Do you or did you have any diseases indicated hereafter?

Diabetes	☐	☐
Blood diseases, e.g. coalgulation deficiencies or prolonged bleeding at injuries	☐	☐
Thyroid disorder	☐	☐
Asthma / lung disease	☐	☐
Nervous disease	☐	☐
Liver disease (icterus, hepatitis A,-B,-C)	☐	☐
Rheumatism/ rheumatic fever	☐	☐
Kidney diseases	☐	☐
Epileptic seizures	☐	☐
Stomach or bowel diseases	☐	☐
HIV + / AIDS	☐	☐

	Yes	No
Do you have any allergies? If yes, which type? _____ _____	☐	☐
Do you take any anticoagulants, e. g. Marcumar, ASS 100?	☐	☐
Do you have any drug intolerances? If yes, which ones_____ _____	☐	☐
Do you have any other illnesses currently? If yes, what kind of _____	☐	☐
Do you take any drugs currently? If yes, which ones_____ _____ _____		
Have you been in medical attention because of a significant disease within the last two years ?	☐	☐
When did you have your last x-ray examination? Date (ungefähr)_____ Organ (e.g. tooth, upper jaw, lower jaw): _____		
Do you smoke regulary?	☐	☐
Female Patients: Are you pregnant?	☐	☐

_____

Date / Signature