Medical History Form

All information and details are subject to medical confidentiality and data protection regulations. They will be treated with strict confidentiality.

Personal Information:

- Name, First Name: _____ Date of Birth: ____._____._____
- Street: _____ ZIP Code: _____ City:_____
- Current Workplace: _____
- Private Phone: _____ Work Phone: _____
- Family Doctor: _____ Doctor's Phone: _____

Health Insurance Information: ☐ statutory health insurance ☐ eligible for aid benefits

☐ Private health insurance ☐ (basic rate?)

Known Pre-existing Conditions: (Please check the appropriate boxes!)

Cardiovascular Diseases

- High Blood Pressure ☐ _____
- Low Blood Pressure ☐ _____
- Heart Valve Disease/ Replacement ☐ _____
- Heart Surgery/Pacemaker ☐ _____
- Heart Disease/Attack/ Arrhythmias ☐ _____
- Endocarditis ☐ _____
- Other ☐ _____

Infectious Diseases

- Tuberculosis ☐ _____
- Hepatitis ☐ _____
- HIV/AIDS ☐ _____
- Other ☐ _____

Allergies

- Antibiotics ☐ _____
- Local Anesthetics ☐ _____
- Metals ☐ _____
- Dental Materials ☐ _____
- Other ☐ _____

Other Conditions

- Blood Disorders/
  Blood Coagulation Disorders ☐ _____
- Asthma/Respiratory Diseases ☐ _____
- Diabetes ☐ _____
- Epilepsy ☐ _____
- Osteoporosis ☐ _____
- Cancer ☐ _____
- Kidney Disorders/Liver Diseases ☐ _____
- Thyroid Diseases ☐ _____
- Glaucoma ☐ _____
- Other ☐ _____

General Information

- Previous Orthodontic Treatments ☐ _____
- Previous Jaw Surgeries ☐ _____
- X-ray Pass Available ☐ _____

What medications are currently being taken?

_____
_____
_____
_____
_____

I commit to informing you of any changes that occur during the entire treatment period.

_____, on _____Signature: _____