Particulars/Health questionnaire

Al of your data under care of the Physican's secretary

Please fill out in capital letters!

UNIVERSITÄT BERN

Family name ..... **First name** .....

Street ..... **Zipcode, /-Place of residence** .....

Date of birth **Day** ..... **Month** ..... **Year** .....

Telefphone **Private** ..... **Business** ..... **Mobile** .....

e-mail .....

Nationality ..... **Work Parmit:** **A** ☐ **B** ☐ **C** ☐ **F** ☐ **L** ☐ **N** ☐

Profession ..... **Employer** .....

For children
Mother's / Father's name or guardian's name .....

Insurance ..... **Police Nr.** .....

Referred by ..... **Family doctor** .....

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1. Are you in good health at the moment? yes ☐ no ☐
2. Are you presently in treatment for any health problem? yes ☐ no ☐
3. Are you taking any medicines regularly? yes ☐ no ☐
   If so, which? .....
4. Have you ever had a severe infection? yes ☐ no ☐
5. Have you ever had jaundice / hepatitis? A ☐ B ☐ C ☐ yes ☐ no ☐
6. Have you ever had a HIV-test? yes ☐ no ☐
   Are you a carrier of the HIV-Virus? yes ☐ no ☐
7. Do you have any allergies? Yes ☐ no ☐
   Eg. Penicillin, Latex etc? yes ☐ no ☐
8. Do you have problems with prolonged bleeding? yes ☐ no ☐
9. Are you taking blood thinners? yes ☐ no ☐
10. Do you have or have had any of the following diseases?

Heart-/ circulatory defect/ heartmurmor	yes ☐	no ☐	Nephropathy	yes ☐	no ☐
Pacemaker	yes ☐	no ☐	Thyroid gland disturbance	yes ☐	no ☐
High bloodpressure	yes ☐	no ☐	Epilepsy	yes ☐	no ☐
Stroke or aneurysm	yes ☐	no ☐	Glaucoma	yes ☐	no ☐
Breathing or respiratory ailments	yes ☐	no ☐	Diabetes	yes ☐	no ☐

11. Do you have endocarditis? yes ☐ no ☐
12. Do you or have you ever suffered from another disease? yes ☐ no ☐
    If so which? .....
13. Have you ever had an incident during a dental medical treatment? yes ☐ no ☐
14. Do you smoke? yes ☐ no ☐
    If so, how many cigarettes per day and since when?
15. Do you drink alcohol regularly? yes ☐ no ☐
    If so, how much? .....
16. Do you take any other substances? yes ☐ no ☐
    If so which ones and how often? .....
17. Female patients: Are you pregnant? yes ☐ no ☐
    If so, in which month? .....

You should let your dentist know about any -changes immediately!

Declaration:

I hereby give my permission::

- ***for the requesting of my medical notes and the forwarding of invoices to the financial clearinghouse, if necessary.***
- ***that the data can be published in a anonymised form for research (eg. Masters or Ph.D)***

Date: ..... **Signature:** .....