Universitätsmedizin Rostock

Universität Rostock Traditio et Innovatio

Dental History Form

Personal Details

Last name, first name: _____ Date of Birth: _____

Primary Care Physician / Specialist: _____ Gender: ☐ m ☐ f ☐ div

Is a long-term care grade ___ or legal guardianship ☐ in place? Point of contact:

For women: Pregnancy ☐ Yes ☐ No

General Health

	No	Yes	Clarification
Body implants (e.g. cardiac valve, pacemaker)	☐	☐	
Cardiovascular diseases (e.g. high blood pressure)	☐	☐	
Coagulation disorder (e.g. blood thinning)	☐	☐	
Diabetes	☐	☐	
Thyroid diseases	☐	☐	
Lung-/ respiratory diseases	☐	☐	
Kidney- ☐ or liver diseases ☐	☐	☐	
Osteoporosis ☐ / arthrosis ☐	☐	☐	
Rheumatism ☐ / autoimmune disease ☐	☐	☐	
Neurological diseases	☐	☐	
Allergies (drugs, latex, metals, …)	☐	☐	
Infection diseases (hepatitis ☐, HIV ☐, …)	☐	☐	
Tumour diseases/ chemotherapy/ radiation therapy	☐	☐	
Sleep apnoea / OSAS	☐	☐	
mental illness (depression ☐, anxiety ☐)	☐	☐	

Other medical conditions:

_____

_____

Medication:

Please list all medications you take <u>regularly</u> (including blood thinners, bisphosphonates, and other antiresorptive medications): ☐ see medication list

Please turn over!

Dental History

When did you receive your most recent dental prosthesis (i.e., fixed, removable)? _____ years ago

If you have dental implants, please have your implant pass available.

Regular use of: ☐ Nicotine ☐ Alcohol ☐ Recreational drugs; Amount: _____ / day ☐ No

Have you ever experienced a serious medical emergency during or after dental treatment (e.g., cardiac arrest, respiratory arrest, epileptic seizure, loss of consciousness/fainting, or anaphylactic shock)?
☐ Yes ☐ No If yes, please provide details: _____

Impact on Oral Health (OHIP-5)

How often have you experienced each of the following situations during the last month?

	Never	Hardly ever	Occasionally	Fairly often	Very often
Have you had difficulty chewing any foods because of problems with your teeth, mouth, dentures or jaw?	☐	☐	☐	☐	☐
Have you felt that there has been less flavor in your food because of problems with your teeth, mouth, dentures or jaws?	☐	☐	☐	☐	☐
Have you had painful aching in your mouth?	☐	☐	☐	☐	☐
Have you felt uncomfortable about the appearance of your teeth, mouth dentures or jaws?	☐	☐	☐	☐	☐
Have you had difficulty doing your usual jobs because of problems with your teeth, mouth, dentures or jaws?	☐	☐	☐	☐	☐

Functional limitations/ temporomandibular disorders (3Q/TMD)

	No	Yes
Do you have pain in your temple, face, jaw or jaw joint once a week or more?	☐	☐
Do you have pain once a week or more when you open your mouth or chew?	☐	☐
Does your jaw lock or become stuck once a week or more?	☐	☐

Reason for Visit / Additional Notes:

_____

_____

_____ _____

Place, date Signature patient / representative