Medical history form for adults

Personal data	
Name:	Previous name:
Telephone:	Social insurance number:
Date of birth:	Gender: male ☐ female ☐ diverse ☐
Address:	E-mail:
Special-class (private ward) insurance: yes ☐ no ☐ Insurer: Policy no.:	Supplementary dental insurance: yes ☐ no ☐ Insurer: Policy no.:
Do you have a court-appointed adult representative? yes ☐ no ☐ Name:	Address: Telephone number: E-mail:

Please read the following paragraphs carefully and confirm your consent by signing the last page.

- The University Clinic of Dentistry Vienna is a teaching institution. I acknowledge that treatment may also be provided by students under medical supervision.

- I acknowledge that the organisation of the clinic and teaching means that the course of treatment is divided into many stages, each of which must be monitored by dentists. The entire process requires a considerable amount of time, especially if preliminary treatment or cooperation between different clinical departments is necessary.

- Treatment at the University Clinic of Dentistry Vienna follows a holistic concept for the rehabilitation of the masticatory system, so the treatment period may extend over months or even years.

- I acknowledge that, for the purpose of documenting the course of treatment, imaging examinations as well as photographic or video recordings may be made during treatment and follow-up care.

- Medical research: The University Clinic of Dentistry Vienna is a legally recognised research institution. We use your patient data (including diagnostic imaging, photographic documentations and video recordings) in pseudonymised form for research projects. Names or other direct identifying characteristics will not be published; any analyses are presented in summarised form and do not allow any conclusions to be drawn about you personally. This is done on the basis of statutory provisions (Austrian Research Organisation Act – FOG) and in compliance with the highest data protection standards. Your consent is not required for this; however, you have the right to obtain information. In view of this statutory authorisation, there is no possibility to object. Detailed information on your rights, data processing and the research purposes can be found in our separate “data protection declaration – research” [https://www.unizahnklinik-wien.at/datenschutz/].

Medical data		
What is your main reason for attending? …… ……		
Have you been referred?	Yes ☐	No ☐
If so, by whom? ……		
Who is your treating dentist? ……		
Are you currently receiving medical treatment? e.g. general practitioner (GP), internal medicine specialist	Yes ☐	No ☐
If so, with whom? ……		
Have you recently been admitted to hospital?	Yes ☐	No ☐
If so, why? ……		
Do you regularly take medication or receive injections?	Yes ☐	No ☐
If so, which medications / injections? ……		
Do you have an allergy? e.g.: Drug allergy, metals, pollen	Yes ☐	No ☐
If so, which medications / injections? ……		
Are you pregnant? Could you be pregnant? If so, in which week?.....	Yes ☐	No ☐
Do you bleed for a long time after injuries?	Yes ☐	No ☐
Are you taking any anticoagulant medication? e.g. Marcoumar, Xarelto, Aspirin, Plavix, Thrombo-Ass	Yes ☐	No ☐
If so, which medications / injections? ……		
Do you have a disease affecting the blood-forming system? e.g. leukaemia, lymphoma, agranulocytosis, anaemia, haemophilia	Yes ☐	No ☐
If so, which medications / injections? ……		

Do you have a disease of the blood vessels? Migraine, arterial circulatory disorder, venous disease, thrombosis	Yes ☐	No ☐
If so, which medications / injections? ……		
Do you have a cardiovascular disease? e.g. heart attack, angina pectoris, arrhythmia, heart defect, valve replacement, blood pressure problems	Yes ☐	No ☐
If so, which medications / injections? ……		
Do you have a pacemaker?	Yes ☐	No ☐
Do you have a respiratory disease? e.g. asthma, chronic bronchitis, tuberculosis, tumour	Yes ☐	No ☐
If so, which medications / injections? ……		
Are you a carrier of an infectious disease? e.g.: Hepatitis A, B, C, non-A–B, HIV/AIDS, tuberculosis, gonorrhoea, syphilis	Yes ☐	No ☐
If so, which medications / injections? ……		
Do you have a metabolic or hormonal disorder? e.g. diabetes, gout, adrenal gland disease, thyroid disease	Yes ☐	No ☐
If so, which ones and since when? ……		
Are you insulin-dependent? If so, since when?.....	Yes ☐	No ☐
Do you have an eye condition? e.g. glaucoma	Yes ☐	No ☐
If so, which medications / injections? ……		
Do you have an autoimmune disease? e.g. lupus, polyarteritis nodosa, dermatomyositis, scleroderma	Yes ☐	No ☐
If so, which medications / injections? ……		
Do you have a rheumatic disease? e.g. rheumatic fever, polyarthritis, ankylosing spondylitis	Yes ☐	No ☐
If so, which medications / injections? ……		
Do you have a disease of the nervous system? e.g. stroke, epilepsy, multiple sclerosis, neuralgia, lumbago	Yes ☐	No ☐
If so, which medications / injections? ……		

Do you have a disease of the kidneys, urinary tract or prostate? e.g. inflammation, tumour	Yes ☐	No ☐
If so, which medications / injections? ……		
Do you have a disease of the digestive organs? e.g. liver, gastrointestinal tract, pancreas, gall bladder	Yes ☐	No ☐
If so, which medications / injections? ……		
Have you had an organ transplant?	Yes ☐	No ☐
If so, which medications / injections? ……		
Are you immunosuppressed?	Yes ☐	No ☐
Do you have a mental illness? e.g.: Anxiety, depression, schizophrenia, neurosis	Yes ☐	No ☐
Do you drink alcoholic beverages? If so, how much?.....	Yes ☐	No ☐
Are you a smoker? If so, how much?.....	Yes ☐	No ☐
Have you ever smoked? If so, how much?.....	Yes ☐	No ☐

	daily	frequently	sometimes	rarely	never
During the past month, have you had any difficulty chewing food because of problems with your teeth, your mouth or your dentures?	☐	☐	☐	☐	☐
During the past month, have you had any pain in your mouth?	☐	☐	☐	☐	☐
During the past month, have you had the impression that your food did not taste as good because of problems with your teeth, your mouth or your dentures?	☐	☐	☐	☐	☐
During the past month, has it been difficult for you to carry out your everyday activities because of problems with your teeth, your mouth or your dentures?	☐	☐	☐	☐	☐

Vienna, _____
Date

_____
Signature of patient or legal Representative