General questionnaire
medical history

Personal information

....
Last name

....
First name

....
Address

....
Zip code, city

....
Phone number

....
E-Mail

....
Date of birth

....
Health insurance

....
Current profession

Current health issues

If current health issues are the reason for your visit, please describe them briefly.

....

....

....

Illnesses, injuries, surgeries

Do you have serious or recurring illnesses?

No

Yes, namely: ....

Have you had any injuries in the past?

No

Yes, sports injuries: ....

....

Yes, serious injuries caused by accident: ....

....

Yes, surgeries: ....

....

Yes, other injuries: ....

....

Do you have or have you had any problems with your teeth or temporomandibular joints?

No

Yes, namely: ....

Do you have any known allergies or intolerances?

No

Yes, namely: ....

Medications and dietary supplements

Do you take any medication regularly?

No

Yes, namely: ....

....

....

....

Do you take any vitamin or mineral supplements regularly?

No

Yes, namely: ....

....

....

....

Lifestyle habits

Do you smoke?

No Yes, since: .... How often? ....

Do you drink alcohol regularly?

No Yes, namely (what, how often?): ....

Do you do sports?

No Yes, namely (what, how often?): ....

Your health goals

What goals do you have regarding your health?

....

....

....

....

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