Dr. Anke Grund

Oral surgeon
Certified implant specialist

Medical History

Dear patient,

please complete this medical history.

Patient		**Sponsor**	
Last Name	_____	Last Name	_____
First Name	_____	First Name	_____
Street	_____	Street	_____
City	_____	City	_____
Date of Birth	_____	Date of Birth	_____
Home Phone	_____	Home Phone	_____
SSN or ID	_____	SSN or ID	_____

Your dentist _____

Your dental insurance _____

For patients without insurance, payment is due at the time of your surgery.

Do you want a treatment with general anaesthesia? ❒ No ❒ Yes

Did you eat or drink in the last six hours? ❒ No ❒ Yes

⇨

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Do you have any of the following conditions?

	No	Yes	
Blood pressure problems?	❒	❒	high low
Heart disease?	❒	❒	
Heart attack?	❒	❒	
Heart valvular defect?	❒	❒	
Coagulation disturbances?	❒	❒	
Kidney problems?	❒	❒	
Cancer?	❒	❒	
Thyroid problems?	❒	❒	
Diabetes?	❒	❒	
Lung disease?	❒	❒	
Nervous system disorders?	❒	❒	
Chronic Infection? (Hepatitis,HIV,other)	❒	❒	
Other diseases?	❒	❒	
Do you have allergies?	❒	❒	
Do you have allergic reaction of medication?	❒	❒	
Do you take medication for blood clotting?	❒	❒	
Do you take medication for osteoporosis?	❒	❒	
Do you take any medication?	❒	❒	
Do you smoke?	❒	❒	How much?
Do you drink alcohol?	❒	❒	How much?
Are you pregnant?	❒	❒	Week of pregnancy?

I certify that the above information is correct.

Date

Signature

Stand: 12/2017