Anamnesis

Also general diseases can have effects on the dental-medical treatment. So we ask you to fill out this questionnaire. This is added to your personal documents. Please note that this information are liable to medical discretion. They serve exclusively to adapt our treatment to your state of health. Partly they are regulated by law. If it is necessary, your data are stored by us. But they subject to strict conditions of privacy.

_____

last name first name male/female birthday

_____

insurance

adress: _____

postcode city street + number telephone number (phone private)

email: _____ mobile number:_____

employer: _____ profession: _____

phone office: _____

name and address of the family doctor:_____

Medical anamnesis		**Yes**	**No**
cardiovascular disease: (heart/circulation)	cardiac insufficiency	☐	☐
	flutter heartbeat (arrhythmien)	☐	☐
	cardiac asthma, angina pectoris	☐	☐
	pacemaker, cardiac valve.....	☐	☐
	high blood pressure	☐	☐
	low blood pressure	☐	☐
	heart attack, when?	☐	☐
	intake of anticoagulant medicaments ……	☐	☐
	faintings	☐	☐
metabolism disease:	diabetes	☐	☐
	gastro-intestinal diseases	☐	☐
	thyroid diseases	☐	☐
disease of nervous system:	epilepsy (fits/convulsions)	☐	☐
blood diseases:	bleeding tendency (hämophilie)	☐	☐
	anemia	☐	☐
allergy:	ekzeme	☐	☐
	penicillin -intolerance	☐	☐
	asthma	☐	☐
	Have you an allergy pass?	☐	☐
	other intolerances(latex, anaesthetics,antibiotics,…): _____		
infectious diseases:	hepatitis A ,B or C/ icterus……..	☐	☐
	tuberculosis	☐	☐
	chronic diseases – asthma, lung diseases, bronchitis……..	☐	☐
	AIDS, HIV	☐	☐
immune system:	diseases of immune system?.....	☐	☐
	When yes, which? _____		
Other diseases:	_____		
Which medicaments do you take in?_____			
more details:	Are you or were you addicted to drugs?	☐	☐
	Are you newly operated?	☐	☐
	When was your last dental x-ray? _____		
	Are you pregnant? (which month: .....)	☐	☐
	Which additives do you use for dental care? _____		

_____

date, signature patient/insurant