ANAMNESIS FORM

Zahnarztpraxis
Dr. Martin Stoltenberg

Dear patient,

before we talk about your dental wishes, we need some information on your person as well as your general medical condition, since generalised diseases can also have an effect on the dental treatment. Please fill in this questionnaire, it will be added to your personal patient file. As a matter of course all information is subject to the medical confidentiality of our practice.

Personal data

Surname / First name _____ Date/place of birth _____

Street / no. _____ Postcode / City _____

Private phone _____ Mobile phone _____

E-Mail _____ Occupation _____

Health insurance company _____

Are you eligible for benefits? ❍ yes ❍ no

In the case that you are not a health insurance member yourself, who is the insured person?

Surname, first name _____ Date of birth _____

Street / no. _____ Postcode / City _____

Who is your GP?

Name _____ Place _____

Phone _____

Organisation

If you cannot keep an appointment, please cancel it at least 24 hours before.

On our own account

How did you hear about our practice?

❍ recommendation (family / friend) ❍ phonebook / trade directory ❍ newspaper advertisement

❍ referral from _____

❍ internet, website: _____ ❍ others _____

If we were recommended, did you visit our website beforehand? ❍ yes ❍ no

Would you like to receive our practice newsletter by E-Mail? ❍ yes ❍ no

Would you like to be reminded of your semi-annual check-up? ❍ yes ❍ no

- please turn over -

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Why do you visit us? You require a ...

- ❍ routine examination
- ❍ advice
- ❍ pain treatment
- ❍ new dentures
- ❍ "second opinion"
- ❍ other reasons:

Are you suffering from acute pains? ❍ **yes** ❍ **no**

If yes, which kind of pain?

- ❍ permanent pain
- ❍ teeth react to sweet / sour
- ❍ some teeth are temperature-sensitive
- ❍ teeth hurt under applied pressure or when chewing
- ❍ teeth also hurt without applied pressure
- ❍ pains or inflammation of the gum
- ❍ pains of the jaw / jaw joint

Do you suffer or have you ever suffered from diseases of the ...

Cardio-vascular system	❍ yes	❍ no
Liver	❍ yes	❍ no
Kidneys	❍ yes	❍ no
Thyroid gland	❍ yes	❍ no
Gastro-intestinal system	❍ yes	❍ no
Joints (rheumatism)	❍ yes	❍ no
Spine	❍ yes	❍ no

Do you suffer or have you ever suffered from ...

High blood pressure	❍ yes	❍ no
Low blood pressure	❍ yes	❍ no
Diabetes	❍ yes	❍ no
Gum bleeding	❍ yes	❍ no
Buzzing in the ears / tinnitus	❍ yes	❍ no
Epilepsy	❍ yes	❍ no
Glaucoma	❍ yes	❍ no
Thyroid disease	❍ yes	❍ no
Rheumatism	❍ yes	❍ no
Tuberculosis	❍ yes	❍ no
HIV (Aids)	❍ yes	❍ no
Hepatitis	❍ yes	❍ no
If yes, which type? ❍ A ❍ B ❍ C		
Allergies	❍ yes	❍ no

If yes, please describe

Other infections / diseases ❍ **yes** ❍ **no**

About your heart: do you suffer or have you ever suffered from ...

- ❍ an inflammation of the heart valves
- ❍ do you have a pacemaker?
- ❍ angina pectoris
- ❍ a cardiac infarction

Drugs – do you take ..

- ❍ heart drugs
- ❍ pain killers
- ❍ blood thinners, e. g. Marcumar, ASS?
- ❍ other drugs:
- ❍ cortisone (corticoids)
- ❍ antidepressants

Have you ever suffered from an intolerance to drugs or injections?
❍ yes ❍ no If yes, to which?

To our female patients:

Are you pregnant?	❍ yes	❍ no

If yes, for how many weeks?

Finally

Do you grind your teeth?	❍ yes	❍ no
Do you feel emotionally stressed?	❍ yes	❍ no
Do you smoke?	❍ yes	❍ no
Do you nourish yourself low-salt?	❍ yes	❍ no

Questions / remarks:

Date, signature