ANAMNESIS
QUESTIONNAIRE

die Pluszahnärzte®

Name: _____ First name: _____ Birthdate: _____

Street/house no.: _____

Postal code:_____ City:_____ Nation: _____

E-mail: _____ Mobile: _____
(please note that we may use your details to forward medical data and information to you)

Profession: _____ Employer: _____

Name of health insurance: _____

General condition

	Yes	No
Thyroid disease	☐	☐
Heart disease (e.g. endocarditis) If yes, please specify: _____	☐	☐
Hypertension	☐	☐
Hypotension	☐	☐
Diabetes	☐	☐
Narrow-angle glaucoma (eye diseases)	☐	☐
Blood clotting disorders (e.g. prolonged bleeding from cuts or after surgery)	☐	☐
Allergy to any medication? If yes, please specify: _____	☐	☐
Any other allergies? If yes, please specify: _____	☐	☐
Infectious diseases (Hepatitis/Tuberculosis/HIV)	☐	☐
Any other diseases? If yes, please specify: _____ _____	☐	☐
Artificial joints	☐	☐
Do you take bisphosphonates? (e.g. osteoporosis, bone metastases)	☐	☐
Do you take any other medicine? If yes, please specify: _____ _____	☐	☐

Oral-dental condition

	Yes	No
Is there a particular reason for your visit? _____ _____	☐	☐
Noises in the temporomandibular joint (e.g. when yawning or chewing)	☐	☐
Pain in head/neck area	☐	☐
Do you already have dental prosthesis? If yes, for ____ years	☐	☐
Bleeding gums	☐	☐
Receding gums	☐	☐
Are you interested in particularly intensive prevention against caries and receding gums?	☐	☐
Are you satisfied with the position, color and shape of your teeth? Are you happy with your smile?	☐	☐
Have you ever undergone orthodontic treatment?	☐	☐
Are you a smoker? If yes, _____ cigarettes a day	☐	☐

Female patients

Are you pregnant?

Yes ☐ No ☐ Uncertain ☐

If yes, I am _____ weeks pregnant

We request that you notify us immediately if you become pregnant during your planned treatment period so that we can take any necessary safety precautions.

Special requests for my dental treatment:

_____

_____

_____

We would like to point out that your fitness to drive is limited after a local anesthetic and ask you to inform us immediately of any changes in your state of health.

If you are unable to make use of a reserved treatment time, please cancel at least 48 hours in advance.
You are doing us and your fellow patients a great favor, as we will otherwise not be able to reallocate the time reserved for you. Downtime can be charged according to paragraph 615, sentence BGB, 287 ZPO.

Please pay attention to the service times of your dentist (SGB V, § 76 (3), p.1 “Change of doctor in the quarter”).

I hereby declare that the information provided is complete and correct. I have taken note of all the information in this medical history form. All entries were made either by me personally or by my legal representative in the practice.

_____ _____

Date Signature (legal representative in case of minors)