Anamnesis questionnaire adults

Fields marked with an asterisk (*) are mandatory.

Dr. Svantje Held

Dr´s office of modern orthodontics

(please write distinctly and in capital letters)

☐ female* ☐ male*

surname*: prename*: date of birth*:

street*: postcode/city*:

tel./cell phone nr.*: email*:

Are you insured with your family? ☐ yes ☐ no

If so, at whom?

name **tel./cell phone nr.**

street **postcode/city**

→ **name of your treating dentist*:**

legal health insurance company name:

covered private insurance:

allowance or subsidy office:

pensioner:

Are you already treated orthodontically or in further times? ☐ yes ☐ no

Orthodontist name ☐ when?

Cardio-vascular diseases

high blood pressure	☐ yes ☐ no	low blood pressure	☐ yes ☐ no
heart attack	☐ yes ☐ no	stroke	☐ yes ☐ no
heart surgeries	☐ yes ☐ no	disturbance in coagulation of the blood	☐ yes ☐ no
endocarditis (bacterial endocardium disease)	☐ yes ☐ no	cardiac valvular effect	☐ yes ☐ no

actual medication for heart and blood pressure:

rheumatism diseases: ☐ yes ☐ no

medication for rheumatism diseases:

Please notice the backside of the questionnaire (S.2)

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Infectious diseases

HIV Infection / AIDS: ☐ yes ☐ no

Hepatitis: (if so, which kind of ☐A ☐B ☐C ☐D) ☐ yes ☐ no

tuberculosis (TB): ☐ yes ☐ no

herpes positive: ☐ yes ☐ no

other infectious diseases, if so, which one?: ☐ yes ☐ no

medications for diseases above:

Cancer/ tumors ☐ yes ☐ no

cancer medications:

Other diseases

neurological diseases: ☐ yes ☐ no

epilepsy: ☐ yes ☐ no

lung/pulmonary diseases (dyspnea/asthma/cystic fibrosis mucoviscidosis): ☐ yes ☐ no

diabetes: ☐ yes ☐ no

thyroid diseases: ☐ yes ☐ no

gastric-, intestinal,- kidney diseases: ☐ yes ☐ no

immune diseases: ☐ yes ☐ no

osteoporosis: ☐ yes ☐ no

Are you taking bisphosphonates regularly? ☐ yes ☐ no

Other not mentioned diseases or medications? ☐ yes ☐ no

(which ?)

allergies/incompatibilities

allergy ID issued in the year:

latex: ☐ yes ☐ no

nickel or other metals: (if so, which) ☐ yes ☐ no

anesthetics: (if so, which) ☐ yes ☐ no

analgesics: (if so, which) ☐ yes ☐ no

antibiotics: (if so, which) ☐ yes ☐ no

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required trauma of teeth: (if so, which and when?) ☐ yes ☐ no

Do you smoke? ☐ yes ☐ no

Did your dentist take x-rays in the last 2 years? ☐ yes ☐ no

(For women only) Are you pregnant? (if so, in which month of?) ☐ yes ☐ no

☐ **I confirm the accuracy and completeness of my data and agree that phone/mobile and e-mail data may be used by us for consultation and to schedule appointments and reminders.**

☐ **I agree that medical confidentiality cannot always be observed due to the spatial situation in the treatment room.**

City, date: **signature:**