

## ANAMNESIS - MEDICAL HISTORY

First- and Family name: ..... Title: .....

Street: ..... Postal Code, City: .....

Insurance policy nr / date of birth: \_\_\_\_ / \_\_\_\_ Health insurance company: .....

Telephone/private: ..... Cell phone: ..... E-Mail: .....

Profession: ..... Company: .....

On the recommendation of: .....

Reason of consultation : .....

- Do you have **allergies** or **hypersensitivities**? Yes ☐, to..... No ☐
- Do you have a **general disease**? (I.e. diabetes type I / II...) Yes ☐,..... No ☐
- Do you have an **infectious diseases**? (I.e. Hepatitis B / C, HIV / AIDS,...) Yes ☐,..... No ☐
- Do you take **medications** (I.e. bisphosphonates) on a regular basis) Yes ☐ No ☐
- If so, which? .....
- Do you have a **pacemaker**, an **artificial heart valve**, etc? Yes ☐ No ☐
- Do you have an **artificial** prosthesis (knee, hip, etc.)? Yes ☐, since..... No ☐
- **Did you ever have a problem with:**
  - ☐ heart ☐ stomach-bowel ☐ thyroid gland ☐ diabetes ☐ blood circulation
  - ☐ liver ☐ blood ☐ rheumatism ☐ lung ☐ kidney
  - ☐ epilepsy ☐ blood pressure
- Do you regularly take **anti-coagulation medicines**? (Marcoumar, Sintrom, etc.)? Yes ☐,..... No ☐
- Do you have an increased **bleeding tendency**? Yes ☐ No ☐
- Did you ever have an **unpleasant reaction** to a dental anesthetic? Yes ☐ No ☐
- Do you want to be included in our **oral hygiene program** and be reminded by E-Mail / Mail? Yes ☐ No ☐
- Do you smoke – or have you ever smoked? Yes ☐ ..... Cig / day (until ..... ) No ☐
- For women: Are you **pregnant**? Yes ☐ No ☐

We ask you to inform us about any changes of your health conditions or medications. We also like to inform you that during the local anesthesia, **you are not allowed to operate a motor vehicle and you should avoid any activities which could be hazardous to you or other people. I also hereby agree that for consultation / examination (such as x-ray, counselling) € 105.-- up to max. € 255.-- could be charged.**

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Signature of patient or legal representative

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Place and date