Anamnesis questionnaire adults

Dr. Maaß & 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)

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

---

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 declare that I degree, that the medical confidentiality can´t be observed permanently because of the spatial Dr´s office situation. ☐ **Yes**

City, date: **signature:**