# Anamnesis questionnaire adults

*(please write distinctly and in capital letters)*

Dr. Svantje Held

Dr´s office of modern orthodontics

☐ 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?

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## 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 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:**