ANAMNESIS QUESTIONNAIRE

ZAHNARZTZENTRUM
ASTRATURM

Henrike Blanke
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Welcome to the Astraturm dental centre!

Before we proceed to have a quiet chat about your dental requirements/problems, we need your personal details and information about both your dental and general health. This is essential to ensure your treatment is both appropriate and safe. Patient confidentiality will, of course, be observed when handling your details.

If you have any questions about filling in this form, we would be happy to help you.

PERSONAL DETAILS

Family name ..... Title .....

First name ..... Date of birth .....

Street, No. ..... Town, postcode .....

Home tel. ..... Mobile tel. .....

Email ..... Occupation .....

Employer ..... Work tel. .....

Insurance

☐ Private Name .....

where relevant: ☐ basic tariff

☐ German „Beihilfe“ scheme ☐ other

☐ Statutory health insurance

Name .....

☐ Supplementary insurance policy

Name .....

If you are not personally a member of a health insurance scheme, who is the named member?

Family name ..... Title .....

First name ..... Date of birth .....

Street, No. ..... Town, postcode .....

Invoice address (if different)

Family name ..... Title .....

First name ..... Date of birth .....

Street, No. ..... Town, postcode .....

QUESTIONS ABOUT YOUR DENTAL HEALTH

When was your last visit to the dentist?

.....

When was the last time your teeth were x-rayed?

.....

Do you have toothache?

☐ Yes, as follows/where .....
☐ No

When was the last time your teeth were scaled and polished?

.....

Do you have receding gums?

☐ Yes ☐ No

Do your gums bleed?

☐ Yes ☐ No

Do you experience any sound/pain in your Yesw joint (e.g. clicking)?

☐ Yes, as follows/where .....
☐ No

Do you grind or clench your teeth?

☐ Yes ☐ No

QUESTIONS ABOUT YOUR GENERAL HEALTH

Cardiovascular disease
(heart attack, stroke, coagulation disorder)

☐ Yes .....
☐ No

Liver disease

☐ Yes .....
☐ No

Kidney disease

☐ Yes .....
☐ No

Respiratory disorders (e.g. asthma, tuberculosis)

☐ Yes .....
☐ No

Gastrointestinal diseases

☐ Yes .....
☐ No

Diseases of the nervous system (e.g. epilepsy)

☐ Yes .....
☐ No

Metabolic disorders (e.g. diabetes)

☐ Yes .....
☐ No

Infectious diseases

HIV pos/AIDS ☐ Yes ☐ No
Hepatitis A - B - C ☐ Yes ☐ No
other .....

Other disorders (e.g. glaucoma, osteoporosis)

☐ Yes .....
☐ No

Pregnancy

☐ Yes, how many weeks .....
☐ No

Allergies

☐ Yes .....
☐ No

Have you experienced any problems with local anasthetic (injections) in the past?

☐ Yes .....
☐ No

Nicotine

☐ Yes, how many per day .....
☐ No

Do you take any medication regularly?

☐ Yes .....
☐ No

If you have answered one or several questions with "yes", please provide us with the name and address of your GP and/or relevant specialist where appropriate.

Name .....

Tel. .....

Street, No. .....

Town, postcode .....

OTHER INFORMATION

How did you find out about us?

☐ Recommendation ☐ Internet ☐ Facebook ☐ Other .....

I confirm that the information I have provided is correct to the best of my knowledge.
Important notes: Please make sure you inform us of any changes to your health before your next appointment!

To ensure the best outcomes in your treatment over the long term, we would like to add you to our patient recall system.

Remind me of appointments by: ☐ Email ☐ Text ☐ Post ☐ None

To avoid you experiencing long waiting times, we schedule an appointment time specifically for you. If you are unable to keep the appointment arranged for you, we would ask you to cancel it at least 24 hours before you are due to attend the appointment. In the event of an appointment being missed, we are entitled to invoice you for the time allocated to the planned treatment.

Hamburg,

.....
Date

.....
Signature