



## MEDICAL HISTORY FORM (ANAMNESIS)

Welcome!

Please complete this questionnaire fully and conscientiously.

**POTSDAMDENT**

Praxis für ganzheitliche Zahnmedizin

### Contact Details

Name

Date of Birth

Address

Occupation / Shift Work

Marital Status  Single  Married

Phone (Private)

Phone (Mobile)

Email Address

### Type of Insurance

Private  Statutory

Insurance / Health Insurance

Allowance  Supplementary Insurance

### General Practitioner

Name

Address

Phone Number

Medication List  Yes  No

Allergy Passport  Yes  No

### How did you hear about us?

#### Recommendation by

#### Referred by

- Internet
- Website
- Google
- Facebook / Instagram
- Rating portals  
(e.g. wameda, Arzt-Auskunft, imedo)
- Other:

### CONSENT DECLARATIONS

#### Storage and Processing of Personal Data

I consent to the collection, electronic storage and processing of my personal data in compliance with the applicable provisions of national data protection laws as well as the General Data Protection Regulation (GDPR), and I agree that all practitioners working in this practice may have access to my personal data.

Yes, I consent

Date, Signature

#### Release from Confidentiality

In the event of further or co-treatment by other dentists/physicians, I release Mr. Svilen Stoyanov from the duty of confidentiality and agree that my dental treatment records (treatment records, X-rays, models, etc.) as well as further information about the treatment may be transmitted to further or co-treating dentists/physicians upon request.

Yes, I consent

Date, Signature

## General

Gender  Female  Male  Diverse

For Women:  
Pregnant?  Yes  No

If yes, week:

Acute medical complaints?  Yes  No

Acute dental complaints?  Yes  No

Known trauma?  Yes  No

Dental treatments in the last 3 years:

Height / Weight  /

Fitness (1-6)

1  2  3  4  5  6

Care level?  Yes  No

Incontinence?  Yes  No

## Treatment

Infection?  Yes  No

Recent medical treatment?  Yes  No

Complications in past treatment?  Yes  No

Alcohol-based products allowed?  Yes  No

## Medication

Bisphosphonates?  Yes  No

Medication?  Yes  No

Dietary supplements?  Yes  No

Supplement recommendation desired?  Yes  No

## Cardiovascular Diseases

High blood pressure  Yes  No

Low blood pressure  Yes  No

Heart passport  Yes  No

Heart attack  Yes  No

Pacemaker / valve replacement  Yes  No

Circulatory disorders  Yes  No

Stroke  Yes  No

Thrombosis / embolism  Yes  No

Endocarditis prophylaxis  Yes  No

Increased intraocular pressure  Yes  No

Other cardiovascular diseases  Yes  No

## Allergies / Intolerances

Pain medication  Yes  No

Antibiotics  Yes  No

Latex  Yes  No

Local anesthesia  Yes  No

Iodine  Yes  No

Others  Yes  No

## Chronic Diseases

Rheumatism  Yes  No

Arthritis  Yes  No

Autoimmune disease  Yes  No

Chronic fatigue  Yes  No

Chronic muscle/joint pain  Yes  No

Other  Yes  No

## Infectious Diseases

Hepatitis  Yes  No

A  B  C  D

HIV-positive  Yes  No

Tuberculosis  Yes  No

MRSA / Creuzfeldt-Jakob  Yes  No

Other  Yes  No

## Metabolic Diseases

Diabetes  Yes  No

Typ 1  Typ 2

HbA1c:

Osteoporosis  Yes  No

Other  Yes  No

## Thyroid

Hyperthyroidism  Yes  No

Hypothyroidism  Yes  No

Hashimoto  Yes  No

## Other Diseases

Lung disease  Yes  No

Asthma  Yes  No

COPD  Yes  No

Cancer  Yes  No

Epilepsy  Yes  No

Gastrointestinal  Yes  No

Kidney disease  Yes  No

Eye disease  Yes  No

Other  Yes  No

Family diseases known?  Yes  No

## Lifestyle

Do you do sports?  Yes  No

If yes:

## Dental Aesthetics

Like smiling?  Yes  No

Satisfied with color?  Yes  No

Restorations visible?  Yes  No

Satisfied with alignment?  Yes  No

Consume stimulants?  Yes  No

## Oral Health

Breathing: Mouth  Nose  ?

Bleeding gums  Yes  No

Loose teeth  Yes  No

Sensitivity  Yes  No

Bad breath  Yes  No

## CMD

Grinding/clenching  Yes  No

Head/neck pain  Yes  No

Dizziness/tinnitus  Yes  No

Snoring  Yes  No

## Prosthetics

Prosthetics present?  Yes  No

Chewing difficulties  Yes  No

Pain  Yes  No

Food retention  Yes  No

Concern about fit  Yes  No

## Dental Treatment

Fear?  Yes  No

Second opinion only?  Yes  No

Other questions?  Yes  No

Important to you:

Your goal:

## X-Rays

Last X-ray (when/where)

## Consumption

Smoking  Yes  No

> 10cigarettes  < 10cigarettes

Smoked before  Yes  No

Other substances  Yes  No

Frequency:

Several times daily  Daily  
 Weekly  Irregular

## Nutrition

Diet:

Healthy  Moderate  Unhealthy

Meals per day:

Sugar intake  Yes  No

Dairy  Yes  No

Bread/grains  Yes  No

## Recall

Reminder desired  Yes  No

Check-up

Professional cleaning

Recall via SMS

Regular cleanings and check-ups are essential

I confirm the accuracy of my information.

Date, Signature

If you cannot attend, please cancel in advance. Missed appointments may be charged.  
Please inform us of any changes.

Date, Signature