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Consultations sur Rendez-vous

CENTRE MEDICO DENTAIRE
FAIENCERIE

# Anamesis-Form

## Dear patient,
## Welcome to our dental practice

Before we start consultation or treatment we need some information on your person as well as your general condition,in order to ensure best possible dental treatment and care. As a matter of course all information is subject to the medicalconfidentiality.

| **1 Patient** | | |
|---|---|---|
| Name: ..... | | Language: ☐ Luxembourgian ☐ German ☐ Portuguese ☐ French ☐ Russian ☐ English ☐ Italian |
| First name.: ..... | | |
| Date of birth: ..... | Insurance no.: ..... | Health insurance: ..... |
| Street/no: ..... Postcode: ..... City: ..... | Private phone:..... Business phone:..... | Mobile phone :..... E-Mail: ..... |
| **2 Legal guardian** | | |
| Name: ..... | | Language: ☐ Luxembourgian ☐ German ☐ Portuguese ☐ French ☐ Russian ☐ English ☐ Italian |
| Firstname: ..... | | |
| Date of birth: ..... | Insurance no. :..... ..... | Health insurance :..... |
| Street/no: ..... Postcode:..... City: ..... | Private phone:..... Business phone: ..... | Mobile phone:..... E-Mail: ..... |

If you cannot keep an appointment, please cancel it – free of cost – at least 24 hours before.

**Please keep us informed of any changes in your personal data!**

* Luxembourg ..... .....,.....

Place, date — Signature patient / legal guardian

| | | |
|---|---|---|
| Medical treatment: | Are you at present in general medical treatment? If yes, because of which illness? ..... | ☐ yes ☐ no |
| Orthodontal treatmant: | Were or are you in orthodontal treatment? If yes: how long? Name of orthodontist? ..... | ☐ yes ☐ no |
| Recommended by: | ..... | |
| What is the reason for your visit?: | ..... | |
| Last visit to your dentist? Date: | | |
| Is a periodontal treatment scheduled? | | ☐ yes ☐ no |
| Is a dental prosthesis/replacement scheduled? | | ☐ yes ☐ no |
| Is a treatment of root canal scheduled? | | ☐ yes ☐ no |
| Is an extraction of tooth scheduled? | | ☐ yes ☐ no |
| Did you have an accident concerning your face/skull? If yes when:..... | | ☐ yes ☐ no |
| Were teeth injured? | | ☐ yes ☐ no |

**Please turn =>**

| | | |
|---|---|---|
| X-Ray: | Last year, was a x-ray of your head-neck-throat taken?<br>…….<br>If yes: when? Wher ?<br>……. | ☐ yes ☐ no |
| Medication: | Do you take regular medication? If yes, which? | ☐ yes ☐ no |
| | aspirin | ☐ yes ☐ no |
| | painkiller agents | ☐ yes ☐ no |
| | antidiabetic agents | ☐ yes ☐ no |
| | antidepressant agents | ☐ yes ☐ no |
| | Antibiotic agents | ☐ yes ☐ no |
| | anti-inflammatory agents | ☐ yes ☐ no |
| | blood pressure agents | ☐ yes ☐ no |
| | anticoagulant (if yes, which? Precise information, please) | ☐ yes ☐ no |
| | Do you smoke? | ☐ yes ☐ no |
| To our female patients: | (from 12 up) Are you pregnant? | ☐ yes ☐ no |

## Do you suffer or have you ever suffered from the following illnesses/pains ?

| | | |
|---|---|---|
| Heart diseases: | eg. myocardial inflammation, connatal, organic heart defect | ☐ yes ☐ no |
| Diseases of cardio-vascular-system | Disturbance of perfusion | ☐ yes ☐ no |
| | High bloodpressure - Hypertension | ☐ yes ☐ no |
| | Low blood pressure | ☐ yes ☐ no |
| Metabolic diseases: | Diabetes | ☐ yes ☐ no |
| | Thyroid disease/malfunction | ☐ yes ☐ no |
| | Kidney illnesses | ☐ yes ☐ no |
| Diseases of respiratory system: | Asthma | ☐ yes ☐ no |
| | Bronchitis | ☐ yes ☐ no |
| Autoimmune diseases: | Rheumatism | ☐ yes ☐ no |
| Infectious diseases: | Hepatitis A, B or C | ☐ yes ☐ no |
| | HIV ( AIDS ) | ☐ yes ☐ no |
| | Tuberculosis | ☐ yes ☐ no |
| | At present: German meales, scarlatina, morbilli | ☐yes ☐ no |
| Skin diseases: | Do you suffer from skin or veneral diseases? | ☐ yes ☐ no |
| Nerve diseasaes: | Do you suffer from epilepsy? | ☐ yes ☐ no |
| Diseases concerning head | Headache/Migraine | ☐ yes ☐ no |
| Allergies: | Intoleranc to medication?<br>If yes, whiche?.....<br>Intolerance to metals?<br>If yes, which? .....<br>Intolerance to latex?<br>Pollen/grass allergy<br>If yes, which? .....<br>Other allergies .....<br>Do you have an allergy-passport? | ☐ yes ☐ no<br><br>☐ yes ☐ no<br><br>☐ yes ☐ no<br>☐ yes ☐ no<br><br>☐ yes ☐ no<br>☐ yes ☐ no |

Additional indication/data:

.....

**During the treatment please keep us informed of any changes in your state of health!**

*

Luxembourg, .....

Place, date

Signature patient/legal guradian