Questionnaire prior to the dental treatment
(Anamnesis)

There is a connection between many diseases and teeth. *With these details you will help us to see this and to be able to create a constant and healthy situation in your mouth as well as to improve your health situation in general.*

Name: ____

Date of birth:____

Occupation: ____

Telephone: ____

E-mail: ____

For an effective treatment and to avoid possible complications, please answer the following questions:

1. Have you had any changes in your health in the past year? ☐ Yes ☐ No
   If yes, what?____

2. Have you been hospitalzed in the last three years? ☐ Yes ☐ No
   If yes, why?____

3. Your blood pressure is:. ☐ normal ☐ unstable ☐ high ☐ very high

4. Do you smoke? ☐ Yes ☐ No
   If yes, how many a day?____

5. Do you suffer (or have you suffered) from (any):

- heart and/or circulatory disease? ☐ Yes ☐ No
- hemophilia? ☐ Yes ☐ No
- diabetes? ☐ Yes ☐ No
- liver-, gall complaints or jaundice? ☐ Yes ☐ No
- contagious disease (TBC, syphilis, AIDS) ☐ Yes ☐ No
- respiratory disease or asthma ☐ Yes ☐ No
- nervous disease? ☐ Yes ☐ No
- dizziness, fainting, spasms, indispostion? ☐ Yes ☐ No
- allergies, hypersensitivity? ☐ Yes ☐ No

If yes, to what?____

6. Any further complaints or illnesses which might be important for us to know?

____

____

7. Any operations you have had:

____

____

8. Medicines you regularly take:

____

____

9. Have you in the past few weeks taken any other medication besides these? ☐ Yes ☐ No

If yes, what?____

Acute troubles:

10. Do you have pain in mouth or teeth? ☐ Yes ☐ No

If yes, where? when? appearing? since when?:____________________________

____

Dental anamnesis / case history:

11. Which kind of dental treatments have been carried out in the last 3 years?

____

____

____

____

____

____

Jaw:

12. Troubles/pain in jaw? ☐ Yes ☐ No

13. Is there any cracking noise, gnashing or rubbing? ☐ Yes ☐ No

If yes, which side?____

14. Teeth in right position when biting? ☐ Yes ☐ No

15. Limitation of movement when opening the mouth or moving to one side? ☐ Yes ☐ No?

16. Chronic headache? ☐ Yes ☐ No?

If yes, how often? where (region)?____

17. Pain in cervical vertebra, neck and shoulders? ☐ Yes ☐ No?

18. Chronic ear infections, pain, tinnitus etc? ☐ Yes ☐ No

19. Problems with eyes, strong visual disorder, high eye pressure etc? ☐ Yes ☐ No

20. Orthodontic treatment in the past? ☐ Yes ☐ No

If yes, please give details:

____

____

21. Have you ever worn braces? ☐ Yes ☐ No

If yes: ☐ fixed ☐ removable

22. Have you had depuration? ☐ Yes ☐ No

The last time you had it was:____

23. How often do you brush your teeth a day?____

24. Do you regularly use dental floss? ☐ Yes ☐ No

Date:____________________ Signature:_______________________

Thank you!