Anamnesis

Name / Surname:_____

Date of Birth:_____

Adress:_____

Insurance company:_____

Employer:_____

Phone number private/work/ cell:_____

	Yes	No
Have you been in hospital or medical treatment for the last 2 years?	☐	☐
Have you ever had any reaction on dental injections or medication?	☐	☐
Do you take any anticoagulant pills?	☐	☐
Are you on regularly medication?	☐	☐
Have you ever had problems with long bleeding?	☐	☐
Do you have a heart pacemaker?	☐	☐
Cardivascular disease?	☐	☐
Raised blood pressure?	☐	☐
Low blood pressure?	☐	☐
Any internal disease (diabetes, renal dysfunction, etc.)?	☐	☐
Sickness of your respiratory organ?	☐	☐
Rheumatism?	☐	☐
Anemia?	☐	☐
Epilepsy?	☐	☐
Any infectious diseases (Hepatitis, Aids/HIV, Tuberculosis)?	☐	☐
Any known allergy or hypersensitivity?	☐	☐
Any other disease?	☐	☐
Are you pregnant?	☐	☐
Do you want a regularly check-up?	☐	☐

Once a year ☐ Twice a year ☐

Date / signature_____