Dear Patient

Date / Signature

In order to be able to select the appropriate medication and treatment procedures for your treatment, we ask you to answer the following questions about the general anamnesis.

(Your details are subject to medical secrecy)



Dental German 2011 Kft Matyas kiraly ut 5. HU - 9900 Kormend



+36 70 606 11 15

First name:			Phone landline:	
Surname:			Phone Mobile:	
Date of birth:			Mail:	
Street:			Are you undergoing medical treatment? Yes No	
City:			Name and address of your doctor:	
Country:				
,				
Do you have or have you had any of thes	se dise	ases?	If you answer yes, please fill in additional information	
1. Drug sensitivity / Allergy	Yes	No		
2. Allergy (which)	Yes	No		
3. Seizure disorders (Epilepsy)	Yes	No		
4. Respiratory illnesses (which)	Yes	No		
5. Blood clotting disorder	Yes	No		
6. Diabetes (which type)	Yes	No		
7. Glaucoma (increased eye pressure)	Yes	No		
8. Thyroid diseases	Yes	No		
9. Cardiovascular disease	Yes	No		
9.1 Heart failure	Yes	No		
9.2 Coronary heart disease/Angina pectoris	Yes	No		
9.3 Myocardial infarction	Yes	No		
9.4 Heart rhythm disturbances	Yes	No		
9.5 Cardiac pacemaker	Yes	No		
9.6 Heart valve defect/replacement	Yes	No		
9.7 high blood pressure	Yes	No		
9.8 low blood pressure	Yes	No		
9.9 Lack of blood circulation/stroke	Yes	No		
10. Infectious diseases	Yes	No		
10.1 Hepatitis/Tuberculosis	Yes	No		
10.2 AIDS/HIV	Yes	No		
11. Liver diseases	Yes	No		
12. Gastrointestinal diseases	Yes	No		
13. Kidney diseases	Yes	No		
13.1 Chronic renal insufficiency	Yes	No		
13.2 Dialysis	Yes	No		
14. Osteoporosis	Yes	No		
15. Rheumatoid arthritis	Yes	No		
16. Tumor diseases	Yes	No		
17. Previous surgeries? (which)	Yes	No		
18. Is there a pregnancy?	Yes	No		
19. Do you take any medication? (which)	Yes	No		