Anamnesis

First name……Last name…..……Health insurance…….

Address ……..

Personal ID…… Phone…….

E-mail…….

Do you have any allergy? (Which one)	**yes**	**no**
Do you smoke?	**yes**	**no**
Do you take any medicaments regularly?	**yes**	**no**
Are you pregnant? (Which month)	**yes**	**no**

Last time you were hospitalized? (Which ward)

Do you have any of these diseases?

AIDS, HIV	**yes**	**no**
Asthma	**yes**	**no**
Angina Pectoris	**yes**	**no**
Other heart disease	**yes**	**no**
Infection disease	**yes**	**no**
Diabetes	**yes**	**no**
Epilepsy	**yes**	**no**
High blood pressure	**yes**	**no**

Other important diseases you want to say us about: ……..

Orthodontical care	**yes**	**no**
Parodontological care	**yes**	**no**
Head and jawbone injury	**yes**	**no**

Date of your last visit at dentist: ……..…….

Date of your last X-Ray: ……

We will keep the information on this form confidential. It will be used to help us make your treatment as good as we can in relation with your health state.

Date……

Signature……