Anamnesis form

DENTALSHAPE
LUXEMBOURG
Cabinet Dentaire GLA

To treat you safely, and to write any prescriptions correctly, we need to know about your health and the medication you take. Please fill in this form carefully and bring it to your first appointment, or send it to us in advance. **Please renew this form every two years**, or sooner if your health changes. Your information is strictly confidential and is used only for your care.

Patient details

Surname _____

First name _____

Date of birth _____

Address _____

Postcode _____

Town _____

Country _____

Mobile / phone _____

E-mail _____

Health insurance (and supplementary insurance) _____

Name of your doctor (GP) _____

Address of your doctor _____

To be completed by the dentist

Blood pressure: systolic _____ diastolic _____

Heart rate (pulse) _____ Oxygen saturation _____

Height _____ Weight _____ BMI _____

Last blood test ☐ internal ☐ external _____

Health questionnaire

Please tick Yes or No. If you answer Yes, please also answer the questions underneath.

1.	**Have you had heart bypass surgery?**	☐ Yes	☐ No
2.	**Do you have chest pain or a feeling of tightness in the chest (angina pectoris)?** *If yes:*	☐ Yes	☐ No
	Have you had to reduce your activities?	☐ Yes	☐ No
	Have the complaints increased recently?	☐ Yes	☐ No
	Do you have these complaints at rest as well?	☐ Yes	☐ No
	Has the angina returned despite bypass surgery, balloon angioplasty or laser therapy?	☐ Yes	☐ No
3.	**Have you had a heart attack?** *If yes:*	☐ Yes	☐ No
	Did you have complications afterwards?	☐ Yes	☐ No
	Do you still have complaints?	☐ Yes	☐ No
	Was the heart attack in the last 6 months?	☐ Yes	☐ No
4.	**Do you have a heart defect, heart valve disorder or heart rhythm disorder?** *If yes:*	☐ Yes	☐ No
	Have you had to reduce your activities because of it?	☐ Yes	☐ No
5.	**Do you have an artificial heart valve, a pacemaker or stents?** *If yes:*	☐ Yes	☐ No
	Have you had to reduce your activities because of it?	☐ Yes	☐ No
6.	**Have you had heart or blood vessel surgery in the last 6 months?**	☐ Yes	☐ No
7.	**Do you have a racing or pounding heart without physical effort?** *If yes:*	☐ Yes	☐ No
	Do you need to rest, sit or lie down during an attack?	☐ Yes	☐ No
	Do you become pale, short of breath or dizzy during an attack?	☐ Yes	☐ No
8.	**Do you have heart failure (a weak heart muscle)?** *If yes:*	☐ Yes	☐ No
	Are your legs swollen in the evening?	☐ Yes	☐ No
	Do you need to urinate more than twice at night?	☐ Yes	☐ No
	Do you wake up at night because you are short of breath?	☐ Yes	☐ No
	Do you sleep on more than 2 pillows because of shortness of breath?	☐ Yes	☐ No
9.	**Do you have high blood pressure?** *If yes:*	☐ Yes	☐ No
	Is your upper (systolic) pressure usually between 160 and 200?	☐ Yes	☐ No
	Is your lower (diastolic) pressure usually between 95 and 115?	☐ Yes	☐ No
	Is your upper pressure usually 200 or higher?	☐ Yes	☐ No
	Is your lower pressure usually 115 or higher?	☐ Yes	☐ No
10.	**Do you bleed easily, or do you have a known blood clotting disorder?** *If yes:*	☐ Yes	☐ No
	Do you bleed for more than 1 hour after an injury or a procedure?	☐ Yes	☐ No
	Do you bruise without reason?	☐ Yes	☐ No
11.	**Have you had symptoms of paralysis or speech problems?** *If yes:*	☐ Yes	☐ No
	Have you had a stroke or speech problems in the last 6 months?	☐ Yes	☐ No
	Have you had similar complaints that lasted less than 24 hours?	☐ Yes	☐ No
12.	**Do you have epilepsy?** *If yes:*	☐ Yes	☐ No
	Is your condition getting worse?	☐ Yes	☐ No
	Which medication do you take for epilepsy? _____		
	Is your medication changed regularly?	☐ Yes	☐ No
	Do you still have seizures despite medication?	☐ Yes	☐ No
13.	**Do you suffer from hyperventilation?**	☐ Yes	☐ No

14. **Do you have asthma?** *If yes:* ☐ Yes ☐ No
- Do you have complaints at the moment? ☐ Yes ☐ No
- Is your breathing difficult right now? ☐ Yes ☐ No
- Do you use an asthma inhaler? ☐ Yes ☐ No
- Do you have a fever during an attack? ☐ Yes ☐ No

15. **Do you have lung problems?** *If yes:* ☐ Yes ☐ No
- Do you cough up more than a coffee cup of mucus a day? ☐ Yes ☐ No
- Are you short of breath after climbing 20 stairs? ☐ Yes ☐ No
- Are you short of breath when getting dressed? ☐ Yes ☐ No

16. **Do you have hay fever?** ☐ Yes ☐ No

17. **Have you ever fainted during dental treatment?** ☐ Yes ☐ No

18. **Have you ever had an allergic reaction to medication or medical materials, such as iodine, plasters or latex?** *If yes:* ☐ Yes ☐ No
- Do you take medication for your allergy? Which? _____
- Are you allergic to penicillin or other antibiotics? ☐ Yes ☐ No
- Did the allergy occur during a local anaesthetic? ☐ Yes ☐ No
- Did the allergy occur at the dentist? ☐ Yes ☐ No
- Are you allergic to anything else? What? _____

19. **Do you have diabetes?** *If yes:* ☐ Yes ☐ No
- Which type? _____
- Do you use insulin? ☐ Yes ☐ No
- Do you have low or high blood sugar at the moment? ☐ Yes ☐ No
- Are you treated for heart or blood vessel disease as a result of diabetes? ☐ Yes ☐ No
- Do you follow a ketogenic diet? ☐ Yes ☐ No

20. **Do you have thyroid problems?** *If yes:* ☐ Yes ☐ No
- Has an overactive or underactive thyroid been diagnosed? Which? _____
- Are you being treated for it? ☐ Yes ☐ No
- Do you still have complaints despite treatment? ☐ Yes ☐ No

21. **Do you have a liver disease?** *If yes:* ☐ Yes ☐ No
- For more than 6 months? ☐ Yes ☐ No
- Do you follow a diet or take medication for it? ☐ Yes ☐ No

22. **Do you have a chronic kidney disease?** *If yes:* ☐ Yes ☐ No
- Are you on dialysis? ☐ Yes ☐ No
- Have you had a kidney transplant? ☐ Yes ☐ No
- Do you follow a special diet for it? ☐ Yes ☐ No

23. **Do you have chronic stomach or bowel complaints that made you lose more than 10 kg?** *If yes:* ☐ Yes ☐ No
- Have you had diarrhoea for more than 6 months? ☐ Yes ☐ No

24. **Do you have anaemia with complaints?** *If yes:* ☐ Yes ☐ No
- Which complaints (tiredness, dizziness, etc.)? _____

25. **Do you have, or have you had, a malignant disease (e.g. of the lymph nodes) or a blood disease?** *If yes:* ☐ Yes ☐ No
- Which? _____
- Do you follow a diet or take medication for it? ☐ Yes ☐ No
- Have you received chemotherapy or a bone marrow transplant? ☐ Yes ☐ No
- Have you received radiotherapy to the head, neck or throat? ☐ Yes ☐ No
- Was the radiotherapy less than 5 years ago? ☐ Yes ☐ No

26. **Do you currently have an infectious disease?** *If yes:* ☐ Yes ☐ No
Hepatitis A / B / C / D, HIV, tuberculosis or other? Which, and with which medication, treatment or vaccination? _____

27. **Have you received an orthopaedic implant (e.g. a joint replacement) in the last 3 months?** ☐ Yes ☐ No

28. **Do you take or have you taken medication for osteoporosis (bisphosphonates, e.g. Fosamax, alendronate, or denosumab injections)?** *If yes:* ☐ Yes ☐ No
Which, and since when? _____

29. **Have you ever had to take antibiotics before dental treatment?** *If yes:* ☐ Yes ☐ No
Which? _____

30. **Do you use recreational drugs?** ☐ Yes ☐ No

31. **Do you drink more than 5 alcoholic drinks a day?** ☐ Yes ☐ No

32. **Are you pregnant, or could you be pregnant?** ☐ Yes ☐ No

33. **Do you smoke or vape?** *If yes:* ☐ Yes ☐ No
How many cigarettes per day? _____

34. **Do you currently take any medication?** *If yes:* ☐ Yes ☐ No
For your heart? Which? _____
Blood thinners? Which? _____
For blood pressure? Which? _____
Aspirin or painkillers? Which? _____
For an allergy? Which? _____
For diabetes? Which? _____
Prednisone, corticosteroids or similar? Which? _____
For acidity / heartburn? Which? _____
For skin or bowel disease, or rheumatism? Which? _____
For cancer or a blood disease? Which? _____
Penicillin or other antibiotics? Which? _____
Sedatives, sleeping pills or antidepressants? Which? _____
Do you take strong painkillers (opioids) daily? Which? _____
Other medication? Which? _____

35. **Do you currently take food supplements? If yes, tick them in the table below.** ☐ Yes ☐ No

Food supplements

Vitamins
- ☐ Vitamin A
- ☐ Vitamin B1
- ☐ Vitamin B6
- ☐ Vitamin B9 (folate)
- ☐ Vitamin B12
- ☐ Vitamin C
- ☐ Vitamin D
- ☐ Vitamin E
- ☐ Vitamin K1
- ☐ Vitamin K2
- ☐ _____

Minerals
- ☐ Magnesium
- ☐ Zinc
- ☐ Selenium
- ☐ Chromium
- ☐ Calcium
- ☐ Molybdenum
- ☐ Potassium
- ☐ Iron
- ☐ Copper
- ☐ Silicon
- ☐ _____

Fatty acids
- ☐ Omega-3
- ☐ Omega-6
- ☐ Omega-9
- ☐ _____
- ☐ _____

Amino acids
- ☐ L-Tyrosine
- ☐ L-Proline
- ☐ L-Theanine
- ☐ L-Methionine
- ☐ L-Carnitine
- ☐ L-Glutamine
- ☐ L-Lysine
- ☐ L-Arginine
- ☐ L-Cysteine
- ☐ Glutathione
- ☐ _____

Amino acid blends
- ☐ BCAA
- ☐ GABA
- ☐ DLPA
- ☐ _____
- ☐ _____

Phytonutrients
- ☐ _____
- ☐ _____

Algae
- ☐ Chlorella
- ☐ Spirulina
- ☐ Astaxanthin
- ☐ _____
- ☐ _____

Essentials
- ☐ Q10 (ubiquinone)
- ☐ MSM
- ☐ Detox
- ☐ _____
- ☐ _____

Anti-inflammatory
- ☐ Bromelain
- ☐ Papain
- ☐ Quercetin
- ☐ Curcuma
- ☐ _____

36. **Are you afraid of dental treatment?** *If yes, how much, on a scale from 1 (a little) to 10 (extremely)?* _____ ☐ Yes ☐ No

37. **Do you have any illness or disorder that was NOT asked about here?** ☐ Yes ☐ No
Which? _____

38. **Do you do sports or follow an exercise therapy?** ☐ Yes ☐ No
Which, and how often? _____

Nutrition diary

39. What do you eat and drink during a typical week? Please mention carbohydrates, sugar, fats, coffee or tea, and tobacco.

	Breakfast	Lunch	Dinner	Snacks & drinks
Mon				
Tue				
Wed				
Thu				
Fri				
Sat				
Sun				

Type of diet (e.g. vegetarian, vegan, gluten-free, low-carb) _____

Anything else we should know?

For example, illnesses that run in your family.

_____

_____

_____

_____

Appointments

Please arrive on time for your appointment. If you cannot keep an appointment, please cancel at least 36 hours in advance, so that we can offer the time to another patient. We reserve the right to charge for appointments that are missed without timely cancellation.

I confirm that I have answered these questions truthfully and to the best of my knowledge, and that I will inform the practice of any change in my health.

Date _____ Patient signature _____

Practitioner _____ Practitioner signature _____

To be completed by the dentist: organ function

Heart _____

Lungs _____

Liver _____

Kidneys _____

Bowel _____

Pancreas _____