PRAXIS AM MÜHLENVIERTEL
Medizinisches Versorgungszentrum GmbH

Anamnesis questionnaire

Dear patient, this questionnaire is an important information for our doctors/ dentists for the acceleration of your medical treatment and for the simplification of our office work. It will remain in your medical file. All the informations will be subject of our medical secrecy. With the help of this document we can adapt our treatment to your medical needs.

Please answer the following questions as exactly as it is possible for you! Thanks!

Patient:	**Insurant/ Invoice recipient: If the patient is under age 18**
Last name:	Last Name:
First name:	First name:
Name of birth:	Name of birth:
Date of birth:	Date of birth:
Place of birth:	Place of birth:
Street:	Street:
Zip code and town:	Zip code and town:
Phone: Home: Work: Mobile:	**Phone**: Home: Work Mobile:
Email:	**Email:**
What is your profession? Name of your employer:	
Name of statutory health insurance:	
Name of private health insurance:	
Name of your dentist: **Dr.:**_____	**Name of your physician:** **Dr.:**_____

We ask you to submit your health insurance card and/ or a letter of referral. Otherwise we may state accounts. With your signature you agree with the transmission of your data to the Association of Statutory Health for Physicians and / or Dentists, to your other doctors in charge, to laboratories and to histologists. As a member of a private health insurance you agree with transmission of your data to a collection agency.

We will send you our account appr. 14 days after your medical treamtment.

With your signature on the back of this form you release the doctors / dentists within this office about every information concerning you regarding to the pledge of secrecy.

!!! Please answer the questions on the backside!!!

Please turn …

Anamnesis

Please answer the following questions as exactly as possible. This will support us to evaluate any medical risks concerning your medical treatment in this office.

Please **cross** where applicable or **underline** or **add** if necessary. Thank you!

	Yes	No		Yes	No
Do you suffer from a cardiovascular disease? **Please underline:** (e. g. hypertension, angina pectoris, heart attack, cardiac defect, pacemaker, stent, bypass, heart valve prosthesis) Do you need endocarditis prophylaxis?			Do you suffer from allergies oder incompatibleness: Against medicine: Pollen, house dust, food: Do you have an allergy ID? **Please hand it to us!**		
Do you often suffer from nosebleeding, hematoma or coalgulopathy?			Do you suffer from gastro-intestinal disease? Please name it:		
Do you suffer from Diabetes? Do you take pills? Do you need multiple daily insulin injection therapy?			Do you suffer from renal disease? Do you need dialysis?		
Do you suffer from metabolic bone disease? (**Osteoporosis? Tumor?**) Do you take bisphosphonates? (e. g. Alendronic acid, Fossamax, Bonviva?			Do / Did you suffer from cancer? **Please name it:** Do /did you need a chemotherapy? Do / did you need a radiotherapy?		
Do you **smoke?** How much: Do you drink **alcohol** periodically? How much? Do you take **drugs**: Which:			Do you suffer from a pulmonary disease? (e. g. asthma, COPD?) Others:		
Do you suffer from other diseases, like Multiple sclerosis, myopathy, epilepsy, organ transplant, rheumatism, depression, thyroid hyper- or hypofunction?			Do you suffer from liver disease: Hepatitis A / B / C? AIDS or HIV?		
Please name other diseases!			Are you pregnant? Week of pregnancy: Do you breastfeed?		
Please name all the medicine you take **periodically**:					

Date: _____ **Signature:** _____

Updated on: _____ Signature: _____