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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| C:\Users\Praxis\Desktop\Logo_Dr_Kroemer 02 09 09.jpg  **Anamnesebogen** | | | | | | | | | | | | |
| **Patient** | | | | | | | | | | | | |
| **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| **Vorname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| **Straße, Nr.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| **PLZ, Ort: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| **Geburtsdatum: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | **Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **Telefon privat: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | **Telefon tagsüber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
|  | | | | | | | | | | | | |
| **Versicherter / Zahlungspflichtiger (wenn Sie nicht selbst Krankenversicherungsmitglied sind)** | | | | | | | | | | | | |
| **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| **Vorname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| **Straße, Nr.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| **PLZ; Ort: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| **Geburtsdatum: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |
| **Beruf des Zahlungspflichtigen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Name Krankenkasse oder Versicherung: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| **O** | **Ich bin nicht versichert** | | | **O** | **Ich bin mit Basistarif versichert (betrifft nur Privatversicherte)** | | | | |
| **Wie bzw. durch wen wurden Sie auf unsere Praxis aufmerksam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| https://t4.ftcdn.net/jpg/00/62/06/49/500_F_62064902_QBgJBq29nBO3eaKP0jY1P0K61WDLs5S8.jpg  **Uns würde noch interessieren** | | | | | | | | | | | | |
| **Sind Sie an einer Prophylaxe / Zahnreinigung interessiert? Von vielen Krankenkassen wird dies bezuschusst.** | | | | | | | | | | | | |
| **O** | **JA** | **O** | **Nein** | | | | | | | |
|  | | | | | | | | | | | | |
| **Wie wollen Sie an ihren Vorsorgetermin erinnert werden?**  **Bitte wenden** | | | | | | | | | | | | |
| **O** | **telefonisch** | **O** | **schriftlich** | | | **O** | **Email** | |  | | | | | Email |

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| **Hatten oder haben Sie eine der folgenden Krankheiten?** | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Ja** | | | **Nein** | | |  | | | | | | | | | | **Ja** | | | | **Nein** | | |
| Zuckerkrankheit | **O** | | | **O** | | | Tuberkulose | | | | | | | | | | **O** | | | | **O** | | |
| Rheuma | **O** | | | **O** | | | Leberkrankheiten | | | | | | | | | | **O** | | | | **O** | | |
| Bluterkrankungen | **O** | | | **O** | | | Hepatitis A/B/C (Gelbsucht) | | | | | | | | | | **O** | | | | **O** | | |
| Blutgerinnungsstörungen | **O** | | | **O** | | | Anfallsleiden (Epilepsie) | | | | | | | | | | **O** | | | | **O** | | |
| HIV-Infektion | **O** | | | **O** | | | Schilddrüsenerkrankungen | | | | | | | | | | **O** | | | | **O** | | |
| Herzinfarkt | **O** | | | **O** | | | Schlaganfall | | | | | | | | | | **O** | | | | **O** | | |
| Lähmungen | **O** | | | **O** | | | **Haben Sie eine Pflegestufe ?** | | | | | | | | | | **O** | | | | **O** | | |
| ggf. seit wann? ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | |
| **Nehmen Sie blutverdünnende Medikamente?** | | | | | | | | | | | | | | | | | | | | | | | |
| Welches Medikament? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | Aktueller INR-Wert? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | **Ja** | | | | **Nein** | | | |
| Tragen Sie einen Herzschrittmacher? | | | | | | | | | | | | | | | | **O** | | | | **O** | | | |
| Nehmen Sie regelmäßig Medikamente? | | | | | | | | | | | | | | | | **O** | | | | **O** | | | |
| Wenn ja, welche?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Haben Sie allergische Reaktionen / Unverträglichkeiten auf Medikamente bzw. Materialien** | | | | | | | | | | | | | | | **O** | | | | **O** | | | |  | | | | | | |
| Wenn ja, welche?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Sonstige Gesundheitsfragen** | | | | | | | | | | | | | | | | | | | | | | | | |
| Wie hoch ist Ihr Blutdruck? | | **O** | | | **niedrig** | | | | | **O** | **normal** | | | **O** | | | | **hoch** | | | | | | | | | | |
| Besteht eine Schwangerschaft? | | | **O** | | **Ja** | | | | | **O** | **Nein** | | | **O** | | | | **ungewiss** | | | | | | | | | |
| Wenn ja, welche Woche? **\_\_\_\_\_\_ Woche** | | | | | | | | | | | | | | | | | | | | | |
| Sonstige Angaben / Operationen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Gleich haben Sie es geschafft!!!** | | | | | | | | | | | | | Quellbild anzeigen | | | | | | | | | | | | |
| Rauchen Sie? | | | | **O** | | **JA** | | | **O** | | | **Nein** | | | | | | | | | | | | | | |
| Wenn ja, wie viele Zigaretten pro Tag? **\_\_\_\_\_\_ Stück pro Tag** | | | | | | | | | | | | | | | | | | | | | |
| Wer ist Ihr Hausarzt?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| Wer war Ihr letzter Zahnarzt? (nur für Neupatienten) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| Müssen wir bei der Behandlung auf Besonderheiten achten? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Vielen Dank für Ihre Mithilfe** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Datum / Unterschrift des Patienten oder Erziehungsberechtigten | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |