Anamnesis questionnaire

Name: Date of Birth:

Phone Number:

Is there hypersensitivity to medications, especially local anesthetics?	O Yes	O No
Is there a heart disease?	O Yes	O No
Do you suffer from diabetes mellitus?	O Yes	O No
Are you aware of an increased bleeding tendency?	O Yes	O No
Are you currently being treated with blood-thinning medications? Which ones?	O Yes	O No
I agree with the implementation of the therapy	O Yes	O No
I agree to the transfer of information to the referring physician	O Yes	O No
For women: Is there a possibility of pregnancy?	O Yes	O No
Have you been vaccinated against Covid 19? If yes, when?	O Yes	O No
Do you have a Fever or Corona infection at the moment?	O Yes	O No

If you do not wish to be called by name, please contact the receptionist.

If you have any further questions about possible side effects and risks, please ask the examining physician.

I have been informed that I may remain in the practice for approx. 30 minutes after the injection and that I may only leave the practice with an accompanying person.

I have also been informed that I am not allowed to actively participate in road traffic or similar for at least 8 hours.

With my signature I confirm these instructions.

Date/Signature (Patient/legal Guardian):	Physician:

We take the protection of your data very seriously and comply with the Data Protection Regulation (DSVO), which is displayed in our waiting room for your information.