

Dear patients!

Welcome to our office! By answering the following questions you enable us to make a careful analysis. Your information will of course be treated confidentially. Thank you.

ANAMNESIS ANTI-SNORE-THERAPY

Patients last name, first name:

Date of birth: Female Male

Address:

Home phone: Business phone:

E-mail: Profession:

Health insurance

Private health insurance: Company name:

Compulsory health insurance: Company name:

Have you been treated with an Anti-snore-therapy? Yes No If so, where?

Have you got a CPAP-respirator? Yes No since when?

Do you have problems with the following?:

Do you snore every night? Yes No

Does this depend on consuming alcohol or not? Yes No

Does your snore affect your partner? Yes No

Gaspings at night Yes No

Daytime tiredness Yes No

Headaches in the morning? Yes No

Do you think, that your performance is limited due to your snore? Yes No

Are you repeatedly tired without any reason? Yes No

Do you easily fall asleep while you are reading, watching TV or being at work? Yes No

Do you fall asleep while visiting a cinema or theatre? Yes No

Are you tired quickly while driving a car? Yes No

Is it difficult for you to concentrate for a long period of time? Yes No

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- Have you got a high blood pressure or/and are you on any medication because of that? Yes No
- Do you take sleeping pills on a regular basis? Yes No
- Are you overweight? Yes No
- Have you got problems with your teeth / jaws now? Yes No
- Have you got gingival problems / parodontitis? Yes No
- Have you got a COPD or cough? Yes No
- Are you asthmatic? Yes No
- Are you epileptic? Yes No

Please give us sufficient note if any of the information above changes!

I affirm the completeness and accuracy by my signature:

Berlin, date

(patients signature)

Bitte beim zweiten Termin ausfüllen:

I have received the education paper.

Berlin, date

(patients signature)