Questionnaire to assess general health

Patient name: Date of birth:

Address, telephone number Social security number:

Dear Patient!

To ensure safe and effective treatment, it is important to get an accurate picture of your health. Withholding any information can seriously affect your health. Please read the questions carefully and **ANSWER ALL!!!** Your data will be treated with respect for your privacy and in accordance with the rules of medical confidentiality. Please inform your doctor of any changes in the course of your treatment.

Why did you visit the dentist now? _____

	Yes	No
Do you have any acute complaints?	☐	☐

What medicines are you taking and what are their names?	Yes	No
antibiotic.....	☐	☐
antihypertensive.....	☐	☐
medicine for heart disease.....	☐	☐
anticoagulant.....	☐	☐
medicine for diabetes.....	☐	☐
sedatives, sleeping pills.....	☐	☐
steroid (e.g. prednisolone).....	☐	☐
medicine for epilepsy.....	☐	☐
medicine for osteoporosis.....	☐	☐
medicine for cancer.....	☐	☐
other:	☐	☐

	Yes	No
Are you prone to fainting?	☐	☐
Do you wear a pacemaker (heart rate regulator) ?	☐	☐
Are you allergic to anything?	☐	☐

If yes, to what?

Medication: _____

Other: _____

	Past	Yes	No
Have you had/do you have liver and bile complaints?	☐	☐	☐
Have you had/do you have jaundice?	☐	☐	☐
Have you/have you had any cancer?	☐	☐	☐

Do you have any medical conditions?	Yes	No
cardiovascular disease	☐	☐
(heart attack, arrhythmia, heart failure, stroke)		
diabetes	☐	☐
haematopoietic disease	☐	☐
(haemophilia, leukaemia)		
immune deficiency disease	☐	☐
disease affecting the thyroid gland	☐	☐
lung disease (asthma, TB, COPD)	☐	☐
infectious disease (HIV, hepatitis, TB)	☐	☐
digestive disease (e.g. reflux)	☐	☐
kidney disease	☐	☐
nervous system disease (e.g. epilepsy)	☐	☐
musculoskeletal disease	☐	☐
(osteoporosis, rheumatism, bone tumours)		
autoimmune disease (lupus, Sjögren's)	☐	☐
psychiatric illness (panic, depression)	☐	☐
other :	☐	☐

	Yes	No
Do you drink alcohol regularly?	☐	☐
Do you use drugs?	☐	☐
Do you smoke?	☐	☐

	Yes	No
Have you had a blood transfusion and when (year)?	☐	☐
Are you currently pregnant/breastfeeding?	☐	☐
Are you currently receiving any treatment?	☐	☐
(dialysis, radiotherapy, chemotherapy, other)		
Do you have implants?	☐	☐
(organ, artificial joint)		
Do you ever have epileptic seizures?	☐	☐
Do you ever have hypoglycaemic attacks?	☐	☐

Previous surgeries: Yes ☐ No ☐

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	Yes	No
Have you had any previous problems concerning dental treatment or anaesthesia?	☐	☐

If so, what?

Other important information concerning your health:

	Yes	No
I consent to the examination and treatment of students and to the presence for educational and scientific purposes of persons whose presence is justified by the activities of this higher education institution.	☐	☐

I certify that the information I have provided regarding my medical condition is true and correct.

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Date Patient's signature

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Doctor's signature