Health check questionnaire dentistry / Adult

Name: Date of birth: male/female

Why is this form important for your dentist or dental hygienist? Problems in your mouth can be caused by illness or use of medication. When you are ill or use medication, this can limit dental treatment or it can be necessary to take precautions. It is very important that your dentist takes this into account. Always inform your dentist if anything changes in your health or use of medication. Your details are strictly confidential and will be treated with the utmost respect according to the privacy legislation. Please bring a recent form of medication with you when you have an appointment with the dentist. Your pharmacy can provide you this form.

Have there been any changes in your health over the past couple of months?	No	Yes> if so, what?
Are you currently receiving treatment from a doctor or medical specialist?	No	Yes > please specify
Have you been admitted to hospital in the past years?	No	Yes > what for?
Have you ever had a serious disease?	No	Yes > please specify
Do you have any allergies?	No	Yes > please specify
Have you had a heart attack/cardiac infarction?	No	Yes > when?
Do you have palpitations?	No	Yes
Are you receiving treatment for high blood pressure?	No	Yes > Pressure……. Systolic…….
Do you experience chest pain during exercise and/or emotions?	No	Yes
Do you have swollen ankles/feet?	No	Yes
Are you short of breath during exercises?	No	Yes
Are you short of breath when you lay down in bed?	No	Yes
Do you have a defective or an artificial heart valve?	No	Yes
Do you have a congenital heart defect?	No	Yes
Do you have a pacemaker, neurostimulator or ICD?	No	Yes
Are you currently being monitored by the thrombosis services?	No	Yes
Have you ever fainted at the dentist or during a medical examination?	No	Yes
Do you suffer from hyperventilation?	No	Yes
Do you suffer from epilepsy/falling disease?	No	Yes
Have you ever suffered a cerebral haemorrhage or a stroke (or TIA)?	No	Yes
Do you suffer from pulmonary symptoms such as asthma, bronchitis or chronic cough?	No	Yes > are you short of breath? No/Yes
Do you suffer from diabetes?	No	Yes > do you use insulin? No/Yes
Do you suffer from anaemia?	No	Yes
Have you ever suffered from extensive bleeding after tooth extraction, surgery or injuries?	No	Yes
Do you have hepatitis, yellow fever or any other liver disease?	No	Yes
Do you have a kidney disease?	No	Yes
Do you have chronic stomach complaints?	No	Yes

Do you suffer from a thyroid disorder?	No	Yes
Do you suffer from rheumatism and/or chronic arthralgia?	No	Yes
Have you ever used in the past medication for osteoporosis such as Denosumab or bisphosphonate?	No	Yes > please specify
Do you have a contagious disease?	No	Yes > please specify
Have you ever received radio therapy for a tumour in head and/or neck?	No	Yes
Do you smoke and/or use an e-smoker/vape?	No	Yes > how many per day?
Do you use drugs?	No	Yes > what?
Do you drink alcohol?	No	Yes > how many glasses per week?
Do you use drugs or have you ever used drugs?	No	Yes > please specify
@ women: are you pregnant?	No	Yes > when is your due date?
Do you have a disease that is not mentioned in this list?	No	Yes > please specify
Do you use medication?	No	Yes >

If so, which medicines do you use?

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Notes/Remarks:

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Date: Signature: