Mondzorgkliniek ASKAR

Why is this health questionnaire important?
A number of diseases and medications can affect the oral health. They can also be a cause for restricting certain dental treatments or a reason to take extra precautions. Therefore it is important to know the health status. Your data shall be treated confidentially.

Name: . . . .
Date of birth: . . . .
Gender: . . . .

Circle around the answer of choice (Yes or No).

1. Do you or did you have an illness regarding the following orans ?

- Hart YES / NO If yes, what? ....
- Lungs YES / NO If yes, what? ....
- Stomach YES / NO If yes, what? ....
- Colon YES / NO If yes, what? ....
- Liver YES / NO If yes, what? ....
- Kidneys YES / NO If yes, what? ....

2. Do u use any blood thinners? YES / NO
3. Do u visit the thrombosis service? YES / NO
4. Do u have a blood clotting disorder? YES / NO
5. Do u have a pacemaker? YES / NO
6. Do u have an animal of artificial heart valve? YES / NO
7. Do u use medication for osteoporosis? YES / NO
8. Have u had radiation therapy in the head/neck area? YES / NO
9. Do u have diabetes? YES / NO
10. Do u have a rheumatic disorder? YES / NO
11. Do u have a psychological disorder? YES / NO
12. Do u have a neurologic disorder? YES / NO
13. Do u have a muscle related disorder? YES / NO
14. Do u have dementia? YES / NO
15. Have u ever fainted during dental treatment? YES / NO
16. Do u have hepatitis (type A,B of C)? YES / NO
17. Do u have other infectious diseases (HIV, MRSA,TBC)? YES / NO
18. Are u pregnant at the moment (only for females) YES / NO

Do u have any diseases or disorders which have not been asked? YES / NO If yes, what?

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Please go to the next page

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19. Do u have any allergies? YES / NO If yes, what allergies?

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20. Do you smoke? YES / NO If yes, how many cigarettes a day?

....

21. Do u drink alcohol? YES / NO If yes, how many glasses a week?

....

22. Do u use drugs? YES / NO If yes, which drugs?

....

23. Have u ever used drugs? YES / NO If yes, which drugs?

....

24. Do u use any medication? YES / NO If yes, please write down all of them

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25. Write here any important comments u have for the dentist.

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I declare that I have answered the questions truthfully, completely an correctly:

Date: . . . .

Signature: . . . .

End of questionnaire