**Health Questionnaire**  **For use only within this practice and confidential**.

Name…………………………………….. Initials………………………………………

Surname…………………………………. Date of birth……………………………….

Occupation ……………………………….. M / F………………………………………..

Address ……………………………….. House number:……………………………

Post code and city:……………………….. E-mail……………………………………..

Telephone (home)………………………... Telephone (work)……………..Mobile…….

Physician…………………………………... Telephone Physician……………………….

Dentist……………………………………… (in case of referral or second opinion)

Where are you insured?............................ Insurance number………………………….

Social Security number (BSN)…………………………………………………………………..

Identity Document (e.g. passport, driver’s license)……………………………………………

Who has referred you to us?................................................................................................

Are you currently under care of a physician? Yes / No. If yes, what for?...........................

………………………………………………………………………………………………………

Do you have (or have you experienced) one or more of the following illnesses, symptoms or problems? Please tick which ones.

Congenital heart disease Anemia Drug use

Valve Prosthesis / flaws Epilepsy Blood transfusion

Endocarditis Venereal Disease Stomach complaints

Angina pectoris Diabetes Secondary bleeding

High blood pressure Fainting or dizzy spells Alcohol abuse

Low blood pressure Hepatitis (jaundice) A/B/C Hereditary diseases

Acute rheumatism AIDS/HIV positive Radiation

Thrombosis / Pulmonary Embolism Leukemia Chemotherapy

Asthma / Bronchitis Thyroid abnormalities Heart palpitations

Stroke Organ transplant Tuberculosis

Hemophilia (blood disease) Sudden weight change Dyspnea

Are you currently using any medication? Yes/No. If yes, please specify

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Do you have any allergies? Yes/No. If yes, please specify. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have there been any complications due to any previous dental or medical procedures?

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Do you smoke? Yes//No. If yes, how many per day? \_\_\_\_\_\_ If no, have you ever smoked?

Are you (possibly) pregnant? \_\_\_\_\_\_\_\_\_\_\_\_

Is there anything from your medical history that may be important or relevant to mention? Yes/No.

If yes, please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NB:**

1. Should there be any changes in your medical history, please inform us!
2. In event of necessary intercollegiate consultations, may your personal data and x-rays be sent passed on to dental specialists?
3. Slides and x-rays may be used for academic educational purposes.
4. Set appointments must be cancelled within 1(one) work day in order to avoid unnecessary costs.

Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_