Health questionnaire oral care – adult – **Medical Secret**

Name:……..Date of Birth: - - male/female Patientcode…….

The amount of diseases, abnormalities and the use of mediciation can (strongly) affect your oral health. They may also impose restrictions on your dental treatment or prompt you to take dental treatment precautionary measures. It is therefore in your interest that we are aware of this. Your data will be treated confidentially and is covered by medical confidentiality .You are not obliged to answer all the written questions. You can also do this verbally. Then discuss this with your dentist or dental care professional.

Please circle the answer that most applies to the following questions (yes or no).

Are you allergic to anything? No Yes -> for what?

Did you ever had a heart attack? No Yes -> When?

Do you suffer from palpitations? No Yes

Are you being treated for high blood pressure? No Yes -> What is your bloodpressure?

Do you have chest pain upon exertion? No Yes

Do you become short of breath when you lie flat in bed? No Yes

Do you have a heart valve defect or an artificial heart valve? No Yes

Do you have a congenital heart defect? No Yes

Do you have pacemaker (or ICD) or neurostimulator? No Yes

Have you ever fainted during dental or medical treatment? No Yes

Do you have epilepsy, falling disease? No Yes

Have you ever had a brain haemorrhage or stroke (or TIA)? No Yes

Do you suffer from lung complaints such as asthma, bronchitis or chronic lung problems? No Yes

Do you have diabetes? No Yes -> do you use insuline?

Do you have anemia? No Yes

Have you ever had prolonged bleeding after tooth extraction or after surgery? No Yes

Do have (or had) hepatitis, jaundice or other liver disease? No Yes

Do you have kidney disease? No Yes

Do you have rheumatism and/or chronic joint complaints? No Yes

Do you have a artificial joint? No Yes

Have you had radiation treatment for a tumor in the head or neck? No Yes

Do you smoke? No Yes-> how much per day?

Do you consume alcohol? No Yes

Woman: are you pregnant? No Yes

Do you have any illness or condition that was not asked about? No Yes -> which one?

Are you taking any medications? No Yes -> which one?

Date: - - Signature…….