**Health Questionnaire - adults**

Name: Date of Birth: male *I* female

**why is the health questionnaire important for your dentist and dental hygienist?**

* **complaints in the mouth can be caused by dissease or use of medication.**
* **When you are sick, have an illness or if you use medication it could be a limitation for the dental treatment or could be a reason to take some precautionary measures. It is very important that your dentist takes note.**

**Please inform your dentist in case anything might change in your health or your use of medocine. Your data is covered by medical professional secrecy and is therefore treated confidentially.**

**Please bring a recent medication overview during every visit to your dentist. You can request a recent overview from your pharmacist.**

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| --- | --- | --- | --- |
| Has anything changed in your health in recent months? | No | Yes | If so what? |
| Are you allergic to something? | No | Yes | If yes, for what? |
| Did you have a heart attack? | No | Yes | If yes, when? |
| Do you suffer from palpitations? | No | Yes |  |
| Are you being treated for high blood pressure? | No | Yes | **Under pressure:Upper pressure:** |
| Do you have chest pain during exercise? | No | Yes |  |
| Are you 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 |
| Have you ever experienced endocarditis (heart inflammation)? | No | Yes |
| Do you have a pacemaker (or ICD) or neurostimulator? | No | Yes |
| Have you ever fainted with dental or medical treatment? | No | Yes |
| Do you have epilepsy, falling illness? | No | Yes |
| Have you ever had a brain haemorrhage or stroke (tia)? | No | Yes |
| Do you suffer from lung complaints such as asthma, bronchitus or chronic cough? | No | Yes |
| Do you have diabetes? | No | Yes | Do you use insuline? **Yes / No** |
| Do you have anemia? | No | Yes |
| Have you ever had prolonged bleeding after tooth extraction or after surgery? | No | Yes |
| Have you 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 |
| Have you been irradiated due to a tumor in the head or neck? | No | Yes |
| Do you smoke? | No | Yes | How often? |
| **Women:** are you Pregnant? | No | Yes | When are you due? |
| **Women:** are you breast-feeding? | No | Yes |
| Do you have a disease or condition that has not been requested? | No | Yes | What? |
| Has a medicine been used in the past against, among other things, bone loss (a bisphosnate or denosumab)? | No | Yes | What? |
| Do you use medication? | No | Yes | What? |
| **Datum: Handtekening:** |