HEALTH QUESTIONNAIRE FOR DENTAL INTERVENTIONS

Name:…
Date of birth:.....TAJ number:.....
Mother's name:.....
Address:.....
Phone number:.....
Occupation:.....
Email address:.....

Dear Patients,
Certain medical conditions may pose a risk and influence dental treatment, therefore we should now more about your health. Read carefully and complete the following questionnaire in order to receive appropriate treatment. (Underline the correct answer.) Your health care information is confidential.

Do you faint easily?.....Yes – No

Do you have high blood pressure?.....Yes – No

Do you have low blood pressure?.....Yes – No

Do you have any other problems with your blood circulation?..... .....Yes – No

Do you have allergy?.....Yes – No

- **If yes, what type?**.....

Do you have heart disease?.....Yes – No

- **Do you have heart developmental disease?**.....Yes – No
- **Did you have a heart valve operation?**.....Yes – No
- **Did you have a heart operation?**.....Yes – No
- **Do you have a pacemaker?**.....Yes – No

Did you have a hip replacement operation or did you receive any other prosthesis?.....Yes – No

What medications do you take regularly? .....

Did you take medicine or did you receive injections for osteoporosis?.....Yes – No

Are you sensitive or allergic to medications?.....Yes – No

If yes, what type?: .....

Female patients: Are you pregnant?.....Yes – No

Do you have diabetes?.....Yes – No

Do you have a bleeding disorder? .....

Do you have thyroid disease?.....Yes – No

Do you have rheumatic disease?.....Yes – No

Do you have lung disease?.....Yes – No

Do you have kidney disease? .....

Do you have digestive system disease?.....Yes – No

Do you have osteoporosis?.....Yes – No

IDo you have nervous system disease?.....Yes – No

Do you have immune system disease? (HIV, AIDS).....Yes – No

Do you have any other disease? .....

If yes, what type?.....Yes – No

Do you smoke?.....Yes – No

How much?.....Yes – No

How long have you smoked?.....Yes – No

Do you have hepatitis?.....Yes – No

I give my consent to the proposed dental treatment.

Date:.....

Patient’s signature:.....