EUROCARE
Medical & Dental Center

GENERAL HEALTH QUESTIONNAIRE

* Using this questionnaire,we will inquire about your medical history and use of medication, which can influence your oral health.
* This can have a limiting effect on the treatment or the precautions we may have to take.
* Thanks to this list, we can determine any possible risk that a treatment could have.
* These records will be treated with the up most care and confidentiality.

Date: _____
Name: _____
m/f: _____
Birthdate: _____

Circle the answer most appropriate to you (Yes or No)

1.Has anything changed to your health, in the last couple of months? Yes I No
If yes, what? ----------

2. Are you being treated by a medical specialist? Yes I No
If yes, what for? ----------

3. In the last couple of years, have you been admitted to a hospital? Yes I No
If yes, what for? ----------

4. Have you ever had a life threatehning disease? Yes I No
If yes, which disease?---------- ------

5. Are you allergic to anything? Yes I No
If yes, to what?----------

6. Have you ever had a heart attack? Yes / No
If yes, when?----------

7.Have you ever had palpitations? Yes I No

8. Are you being treated for high blood pressure? Yes I No
If yes, what is your pressure usually?
Non- systolic pressure : ---------- Systolic pressure:----------

9. Do you ever have pain in the chest when you're emotional or exercising? Yes I No

10. Do you ever have swollen ankles or feet? Yes I No

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11. Are you ever short of breath when you lie down? Yes I No

12. When exercising, do you ever get short of breath? Yes I No

13. Do you have a valvular problem or artificial heart valve? Yes I No

13a. Do you have an artificial knee or hip? Yes / No

14. Do you have a congenital heart defect? Yes I No

15. Do you have a pacemaker (or ICD)? Yes I No

16. Are you in the care of the thrombosis service? Yes I No

17. Have you ever fainted during a dental or medical treatment? Yes I No

18. Do you ever suffer from hyperventilation? Yes I No

19. Do you have epilepsy? Yes I No

20. Have you ever had a cerebral hemorrhage or stroke? Yes I No

21. Do you have respiratory problems like asthma, bronchitis or chronic cough? Yes I No
If yes, are you short of breath as well? Yes | No

22. Are you diabetic? Yes I No
If yes, do you use insulin? Yes | No

23. Are you anemic? Yes I No

23a. Do you have a blood disease/blood clogging disorder? Yes | No

24. Have you ever had long-term bleeds, after pulling a tooth or after an operation? Yes I No

25. Do you have (or ever had) hepatitis, jaundice or any other liver disease? Yes I No

26. Do you have a kidney disease? Yes I No

27. Do you have chronical bowel problems? Yes I No

28. Do you have a condition of the thyroid? Yes I No

29. Are you rheumatic and/or do you have chronic joint problems? Yes I No

30. Do you have a contagious disease? Yes I No
If yes, which one?----------

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31. Have you ever received radiation treatment for a tumor to your head or neck? Yes I No

32. Do you smoke? Yes I No
If yes, how often a day? ——————————————

33. Do you consume alcohol? Yes I No
If yes, how often a week?---------- ----------

34. Have you, or do you ever use drugs? Yes I No
If yes, which drugs?----------

35. Are you pregnant? Yes I No
If yes, what is your due date? ----------

36. Do you have a disease or condition not listed above? Yes I No
If yes, which? ----------

37. Do you currently use medication? Yes I No
If yes, please write down what you use:

_____

_____

_____

_____

_____

_____

The following questions concern your dental hygiene and cleaning behavior:

1. How do you brush? ☐Electronically ☐Manually
2. How often do you brush? ☐Daily.....times ☐Weekly.....times
3. Do you clean interdentally? ☐Yes ☐No
   If yes, using what? ☐Floss ☐Wood sticks ☐ Something else:.....
4. Do your gums bleed? ☐Yes ☐No
   If yes, when?
   ……..
5. Do you have any other complaints? ☐Yes ☐No

Source: Bruins, Haalboom & Koole, goedgekeurd door de Vereniging voor Medische Tandheelkunde Interactie (VMTI) (aangepaste versie januari 2009)