NAME : **Date of birth :**

ADDRESS :

Phone number : Phone number at work
Mobil number :
E-mail address :

Health insurance :

General practitioner : Name : City :

1 **Do you experience chest pain upon exertion (angina pectoris)? If so,**
Are your activities restricted?
Have the complaints increased recently?
Do you have chest pain at rest?

2. **Have you ever had a heart attack? If so,**
Are your activities restricted?
Have you had a heart attack in the last 6 months?

3. **Do you have a heart murmur, or heart valve disease, or an artificial heart valve?**
Have you had heart or vascular surgery within the last six months?
Do you have a pacemaker?
Have you ever had rheumatic heart disease?
Are your activities restricted?

4. **Do you have heart palpitations without exertion? If so,**
Do you have to rest, sit down or lie down during palpitations?
Are you short of breath, or pale or dizzy at these times?

5. **Do you suffer from heart failure? If so,**
Are you short of breath lying flat?
Do you need two or more than 2 pillows at night
due to shortness of breath?

6. **Have you now or in the past had high blood pressure?**
Wright down your last know blood pressure **-----/-----**

7. **Do you have a tendency to bleed? If so,**
Do you bleed for more than one hour following injury or surgery?
Do you suffer from spontaneous bruising?

8. Do you have epilepsy? If so,
Is your condition getting worse?
Do you continue to have attacks despite medication ?

9. Do you suffer from asthma? If so,
Do you use any medication and/or inhalers?
Is your breathing difficult today?

10. Do you have other lung problems or a persistent cough? If so,
Are you short of breath after climbing 20 steps?
Are you short of breath getting dressed?

11. Have you ever had an allergic reaction to penicillin, aspirin, latex, dental materials or anything else? If so,
Did this require medical or hospital treatment?
Was it during a dental visit?
What are you allergic to?

12. Do you have diabetes?
Are you on insulin? If so,
Is your diabetes poorly controlled at present?

13. Do you suffer from thyroid disease? If so,
Is your thyroid gland underactive?
Is your thyroid gland overactive?

14. Have you now or in the past had liverdisease?

15. Do you have kidney disease? If so,
Are you undergoing dialysis?
Have you had a kidney transplant?

16. Have you ever had or do you have cancer or leukemia?
Are you receiving drug therapy or have you had
a bone marrow transplant for this?
Which medication.....
Have you ever had X-ray treatment for
a tumor or growth in the head or neck?

17. Do you suffer from hyperventilation?

18. Have you ever fainted during dental or medical treatment?

19. Are you on medication for any reason at present, prescribed or otherwise?
- for a heart complaint?
- anticoagulants?
- for high blood pressure?
- aspirin or other painkillers?
- for an allergy?
- for diabetes?
- Prednisone, corticosteroids (systemic or topical)?
- drugs against transplant rejection?
- drugs against skin, bowel or rheumatic diseases?
- for cancer or blood disease?
- penicillin, antibiotics or antimicrobials?
- for sleeping disorder, depressive condition or anxiety sate?
- have you ever used recreational drugs?
- other medication (prescribed or otherwise)?

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20. Do you have to take antibiotics before dental treatment?

21. Women only, please, are you pregnant?