WICHLIŃSCY
STOMATOLOGIA

## HEALTH CONDITION QUESTIONNAIRE

| | |
|---|---|
| Surname and forename | Second name |
| Address | PESEL (Central Registry Personal Number) |
| Phone no | E-mail |

**Dear Patient!**
Thank you for choosing the Stomatologia Wichlińscy. You entrust health of your teeth to dental specialists with many years' experience.For the purpose of dental treatment which will be safe and most suitable for your health condition we are kindly requesting to complete the Health Condition Questionnaire. The information provided in it is subject to medical confidentiality and will only be disclosed to the dentist.

| | YES | NO | I DON'T KNOW |
|---|---|---|---|
| 1. Are you currently treated by a family doctor? _____ | ☐ | ☐ | ☐ |
| Specify the causa _____ | | | |
| Provide the forename and surname as well as contact details of the family doctor _____ | | | |
| 2. Did you take any medications during the past year? _____ | ☐ | ☐ | ☐ |
| Specify which ones: _____ | | | |
| 3. Have you ever suffered from: _____ | | | |
| hypertension _____ | ☐ | ☐ | ☐ |
| cardiac diseases _____ | ☐ | ☐ | ☐ |
| asthma _____ | ☐ | ☐ | ☐ |
| thyroid diseases _____ | ☐ | ☐ | ☐ |
| jaundice _____ | ☐ | ☐ | ☐ |
| tuberculosis _____ | ☐ | ☐ | ☐ |
| kidney diseases _____ | ☐ | ☐ | ☐ |
| rheumatic diseases _____ | ☐ | ☐ | ☐ |
| peptic ulcer disease _____ | ☐ | ☐ | ☐ |
| osteoporosis or osteopenia _____ | ☐ | ☐ | ☐ |
| other: _____ | ☐ | ☐ | ☐ |

(WE ARE KINDLY REQUESTING TO COMPLETE THE NEXT PART WHICH IS ON THE REVERSE SIDE)

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| | YES | NO | I DON'T KNOW |
|---|---|---|---|
| 4. Have you received steroid therapy / radiotherapy /chemotherapy? | ☐ | ☐ | ☐ |
| 5. Have you ever had an operation or been hospitalized? | ☐ | ☐ | ☐ |
| 6. Have you put on weight or lost more than 5 kilos during the year | ☐ | ☐ | ☐ |
| 7. When you cut yourself, does it take more than 10 minutes before bleeding stops? | ☐ | ☐ | ☐ |
| 8. Do you have any allergies? | ☐ | ☐ | ☐ |
| Specify which ones: | | | |
| 9. Do you happen to experience consciousness disorders (fainting)? | ☐ | ☐ | ☐ |
| 10. Do you smoke cigarettes? Specify how many cigarettes per day: | ☐ | ☐ | ☐ |
| 11. When did you last have an X-ray taken? Write the date or check the box | ☐ | ☐ | ☐ |
| 12.A question to women. Are you pregnant? | ☐ | ☐ | ☐ |
| 13.Do you think it is necessary to change the appearance of your teeth? | ☐ | ☐ | ☐ |
| 14.Do you have problems with biting or chewing the food? | ☐ | ☐ | ☐ |
| 15.Do you have problems with opening the mouth wide? | ☐ | ☐ | ☐ |
| 16.Do you clench your teeth during the day and feel their pain? | ☐ | ☐ | ☐ |
| 17.Do you use or have you ever used a protective occlusal splint? | ☐ | ☐ | ☐ |
| 18. While opening the mouth or eating food, can you hear, crackles' in the ears? | ☐ | ☐ | ☐ |
| 19. Have you had orthodontic treatment? (braces, performed correction of occlusion) | ☐ | ☐ | ☐ |
| 20. Have you ever had any of the following procedures performed | | | |
| (piercing, a tattoo, hair removal procedure, invasive cosmetic procedure, etc.? | ☐ | ☐ | ☐ |
| 21.Do you have or have you ever had problems with paranasal sinuses? | ☐ | ☐ | ☐ |
| 22.Is there anything else you would like to inform the dentist? | ☐ | ☐ | ☐ |

**I am obliged to notify the physician responsible for treatment of any changes immediately.**

Date, signature, seal of the physician

Date, signature of the patient or statutory representative

Can you share the information how you have found out about our Dental Clinic?
(e.g. from your acquaintance, from the Internet, from the commercial)

**Thank you!**
**Team of the Stomatologia Wichlińscy**

Justyna Wichińska, Jarosław Wichliński, Lekarze Stomatolodzy,
**STOMATOLOGIA WICHLIŃSCY GORLICE** Spółka Partnerska
ul. 3-go Maja 16, 38-300 Gorlice

Gorlice +48 513 013 222
www.stomatologiawichlinscy.pl