Simplexcode:

Part 1 : General Information

Surname: ..... Initials.: ..... Sex: M /F*

Name (name you wish to be addressed by): .....

Street :.....(**excl. Postbox number**) House number: .....

Postcode / area code: ..... Town.....…… Date of Birth :.....

Home Tel.: ..... Work Tel. .....Mobile Tel.: .....

Email (private): .....Email (work): .....

Public council registered address :..... Profession: .....

Name Doctor: .....…….....Tel. .....

Name former dentist: ..... Town.....

Kind of dental insurance: private / health insurance / none*

Which health insurance: name insurance company: ..... (AGB number: .....…….....)

Town: ..... Tel ..nr: …….....

Registry Number: .....….. additional insurance: yes / no*

How did you hear about us? .....

* Please apply a circle around the most applicable answer.

Part 2 : Medical Questionnaire

Many medical conditions, medicines used and lifestyle habits can strongly influence your oral and dental health. For us at Tendens, it is important to be informed about your general health and medication use as they can impose restrictions to your dental treatment or require precaution measures before dental treatment. The information you give is treated confidentially as required by law.

Please tick yes or no

	yes	no	ASA
1. **Do you suffer from a pressing pain on the chest during exercise (angina pectoris) ?**	q	q	II
If so,			
- does it cause you to reduce your activities?	q	q	III
- Do you have chest complaints in rest?	q	q	IV
- Are your chest complaints increasing in time?	q	q	IV
- Did you regain chest pain in spite of cardiac surgery/ dotter procedure.....	q	q	IV
2. **Have you ever suffered a myocardial infarction?**	q	q	II
If so,			
- Did complications occur afterwards?	q	q	III
- Do you still experience complaints?	q	q	III
- Did you have a myocardial infarction within the last 6 months?.....	q	q	IV
3. **Do you have a heart murmur, vascular disease or (juvenile) rheumatic fever……**	q	q	II
If so,			
- Does this vascular disease cause symptoms? .....…	q	q	III
- Is you vascular condition treated surgically?	q	q	II
Do you have an artificial heart valve or artificial hip?	q	q	II
If so,			
- Are you free of complaints after the operation for vascular disease?	q	q	III
- Do you require antibiotics before dental treatment?	q	q	II
Did you require cardiac or vascular surgery within the last 6 months?	q	q	II
If so,			
- Was this operation a coronary angio bypass grafting operation?	q	q	II
- Do you still have complaints after this operation?	q	q	III
- Do you still have angina complaints after this operation.....	q	q	IV
Do you have a pacemaker?	q	q	II
4. **Do you suffer from palpitations at rest?**	q	q	II
If so,			
- During these episodes, do you have to sit or rest? .....….....	q	q	III
- Do you turn pale, are you dizzy or short of breath during these episodes?	q	q	IV
- Are you treated with anti-coagulants (e.g. Sintrom/Marcoumar/Warfarin)?	q	q	II
5. **Do you have heart failure?** .....…….	q	q	II
If so,			
- Do you have swollen ankles/legs?	q	q	II
- Do you have to urinate more than 2 times at night?	q	q	II
- Do you sleep with two or more pillows to prevent shortness of breath?	q	q	III
- Do you require rest after 20 steps on the stairs? .....…	q	q	III
- Do you wake at night due to shortness of breath?	q	q	IV
6. **Are you known with Hyperventilation Syndrome or Panic Disorders?**	q	q	

7. **Have you ever fainted during dental or medical treatment?**	q	q	
8. **Do you have high blood pressure?**	q	q	II
If so,			
- is your systolic blood pressure between 160 and 200 mmHg?	q	q	II
- is your systolic blood pressure above 200 mmHg?	q	q	III
- is diastolic blood pressure between 95 and 115 mmHg?	q	q	III
- is your diastolic blood pressure above 115 mmHg?	q	q	IV
9. **Have you ever had paralysis (stroke, CVA) or speech impairments?**	q	q	II
If so,			
- Are you treated by a thrombosis service?.....	q	q	II
- Have you had similar complaints which disappear within 24 hours?	q	q	III
- Did you suffer a stroke or cerebral hemorrhage within the last 6 months?	q	q	IV
10. **Do you use medication for epilepsy?**	q	q	II
If so,			
- Is your medication changed regularly?	q	q	III
- Do your suffer attacks despite medication?	q	q	IV
11. **Do you have asthma?**	q	q	II
If so,			
- Are you currently suffering from shortness of breath?	q	q	III
- Does your medication relief your complaints sufficiently.....	q	q	IV
12. **Do you have weak lungs?**	q	q	II
If yes,			
- do you have tuberculosis?	q	q	II
- do you have complaints from the tuberculosis?	q	q	III
- do you cough up more than a cup of sputum daily?	q	q	II
- are you short of breath after approx. 20 treads of stairs?	q	q	III
- are you short of breath after getting up or dressing?	q	q	IV
13a.**Do you have hay fever?**	q	q	II
b. **Have you ever had an allergic reaction after using medication or medical materials?**	q	q	II
If yes,			
- do you use medication for your allergies?	q	q	II
- did the allergy occur after receiving a local anesthetic?	q	q	II
- did the allergy occur at the dentist?	q	q	II
- are you allergic to penicillin or other antibiotics?	q	q	II
14**. Are you a diabetic?**	q	q	II
If so,			
- do you use insulin?	q	q	II
- are your blood glucose levels unstable (hypo-/hyper glycogenic)?	q	q	III
- are you being treated for heart and vessel complications due to diabetes?.....	q	q	IV
15. **Do you have a hyperthyroid condition**?	q	q	II
if so,			
- are you being treated / checked for this?	q	q	II
- do you still have complaints despite treatment?.....	q	q	IV
Have you lost more than 6 kilos in the last half year without eating less and despite having a good appetite?	q	q	II
If yes,			
- do you get hot faster than others around you?	q	q	II
- do you constantly have sweaty hands and trembling fingers?	q	q	II
16. **Do you have a hypothyroid condition?**	q	q	II
If so,			
- are you being treated /checked for this?	q	q	II

- do you still have complaints despite treatment? ..... q q II

Have you gained more than 6 kilos without a change of diet in the last half year?
..... q q II

If so,
- have you become slower? ..... q q II
- do you get chilled more easily? .... q q II

17. **Have you had a liver condition for longer than 6 months?** ..... q q II

If so,
- have you been admitted in a hospital due to this? ..... q q III
-you have a special diet or medication for this? ..... q q IV

Do you currently have Serum Hepatitis or Hepatitis B? ..... q q II

If so,
- has this been confirmed with blood tests? .... q q II
- are you undergoing treatment or having checkups? ..... q q III

18. **Do you have a chronic kidney condition**? ..... q q II

If so,
- do you have kidney replacement therapy? ..... q q II
-do you have a special diet or medication for this? ..... q q III

19. **Do you have a bowel disorder with diarrhea?** ..... q q II

If so,
-do you regularly have diarrhea at night??..... q q II
- have you had diarrhea longer than 6 months? ..... q q III
- do you have a fever? ..... q q IV

20. **Are you anaemic?** ..... q q II

If so,
- does it give you any complaints like tiredness, dizziness, shortness of breath, headaches? q q III
- Are there any hereditary forms of anaemia in your family? ..... q q III

21. **Do you have a malignant lymph disease or blood disease?** ..... q q III

If so,
- which? .....
- do you have sores or infections in the mouth? ..... q q III
- are you being treated for this but never the less have complaints? ..... q q III
- do you have periodic fevers? ..... q q IV
- transpire profusely at night?..... q q IV

22. **Do you have a bleeding disorder?** .....……. q q II

If so,
- do you bleed longer than an hour after wounds or procedures? ..... q q II
- do you get bruises without knocking yourself / incidents? ..... q q II
- do you use blood anticoagulant medication? ..... q q II
-do you use aspirin more than twice a week to combat sore joints? ..... q q II
- do you or your family have a blood clotting sickness? ..... q q III

23. **Have you received radiation treatment for a tumor or lump in the head or neck area?** q q II

If so,
- was this longer than five years ago? ..... q q II
- was this less than five years ago? ..... q q III
- was this less than one year ago? ..... q q IV

24. **Do you currently have an infectious disease?** ..... q q II

If so,
- which? .....
-are you seropositive? ..... q q II
- do you have AIDs? .....……. q q III

25. **Are you currently using medication?** ..... q q

If so,

- for the heart ?..... q q
- for a high blood pressure?..... q q
- aspirin or other painkillers?..... q q
- for diabetes? ..... q q
- prednisone, corticosteroids or other immuno suppressants ?..... q q
- medication for cancer or blood diseases?..... q q
- penicillin or antibiotics?..... q q
- sedatives, sleeping tablets, antidepressants, narcotics?..... q q
- other medication?..... q q
- do you have thrombosis checks? ..... q q

26. **Are you pregnant?** ..... q q II
If so,
- are you less than three months pregnant? ..... q q III

27. **Do you currently smoke?** ..... q q
If so,
How many cigarettes a day? .....
Do you drink more than 2 glasses of alcohol a day? ..... q q
Do you suffer from stress? ..... q q

28. **Do you suffer from a bad taste in the mouth?** ..... q q
do you have a bad breath?..... q q
- do you notice your bad breath? ..... q q
- do others notice your bad breath? ..... q q

29. **Are your teeth sensitive to:**
- warm or cold temperatures? ..... q q
- sweetness? ..... q q
- chewing or biting? ..... q q

30. **Do you suffer from:**
- bleeding gums? ..... q q
- loose teeth?..... q q

31. **Would you like to keep your teeth for as long as possible?** ..... q q
32. **Are you satisfied with the appearance of your teeth?** ..... q q
33. **When was the last time x-rays were made of your teeth?** .....
34. **Do you often get headaches?** ..... q q
35. **Do your jaws make clicking sounds?** ..... q q
36. **DO you have trouble opening or closing you mouth?** ..... q q
37. **Do you clench or grind your teeth on a regular basis?** ..... q q
38. **Have you ever had a bad experience during a dental treatment?** ..... q q
If so,
- in which way.....
.....
39. **When did you leave your former dentist?** .....
40. **Why did you leave your former dentist?** .....
41. **Could you state in short your wishes and expectations please:** .....
.....
42. **Do you have any comments about this questionnaire?** .....
.....
.....

Part 3 : Your First Visit

- During your first visit x-rays will be made as well as going through this questionnaire. You will be given the opportunity of asking specific questions or discussing any wishes you may have regarding your teeth. Furthermore, follow up appointments will be planned, for example going to the mouth hygienist (cleaning appointment) or possible tooth or teeth. If more extensive treatments are necessary, there will usually be a separate appointment to discus a treatment plan and the involving costs.

- Anyone can pay their treatment bill by cash. If you would like to receive your bill by post, we **require a recent bank account statement in order to cross reference your address**. **If you are not able to comply with this, we require that you pay by cash directly at the end of your appointment (s).**

- Would you please request to your former dentist that they send on recent radiographs as well as other relevant information, and that this be sent before your first appointment at our practice?

Filled in to my best possible knowledge on : .....……..... (date) at .....…….... (place)

SIGNITURE .....……...

Please inform us should any changes occur in the given information.