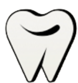

DOBRY DENT

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phone: +420 774 126 537
info@dobrydent.cz

Medical history questionnaire

Surname		**Name**	
Date of Birth		**Insurance company**	
E-mail		**Phone number**	
Address		**How did you hear about us**	☐ internet ☐ leaflet ☐ on recommendation

The following information is required to enable us to provide you with the best possible dental care. All the information is strictly private, and protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

Do you have allergies to any medications?	☐ No	☐ Yes	
Do you suffer from any allergies (latex, hay fever, bees, any food, ...)?	☐ No	☐ Yes	
Have you ever had an epileptic seizure? (another disturbance of consciousness?)	☐ No	☐ Yes	
Do you have a bleeding problem or bleeding disorder?	☐ No	☐ Yes	
Do you have diabetes?	☐ No	☐ Yes	
Have you had any heart disease (heart attack, surgery, pacemaker, ...)?	☐ No	☐ Yes	
Do you have or have you had any infectious diseases (jaundice, tuberculosis, HIV)?	☐ No	☐ Yes	
Have you ever had any blood pressure problems?	☐ No	☐ Yes	
Have you ever had hepatitis, jaundice or liver disease?	☐ No	☐ Yes	
Do you suffer from any lung disease (asthma)?	☐ No	☐ Yes	
Do you have a thyroid disease?	☐ No	☐ Yes	
Have you ever had cancer?	☐ No	☐ Yes	
Do you have any eye diseases (glaucoma or cataracts)?	☐ No	☐ Yes	
Have you ever had any surgery?	☐ No	☐ Yes	What kind?
Do you currently have any other illnesses?	☐ No	☐ Yes	
Are you taking any medications, non-prescription drugs or herbal supplements of any kind?	☐ No	☐ Yes	Which and how often?
For women only: are you breastfeeding or pregnant?	☐ No	☐ Yes	What is the expected delivery date?
Do you smoke or chew tobacco products?	☐ No	☐ Yes	How many cigarettes a day?

___ / ___ / 2022

Date

Signature of the patient or parent (if patient is under 18 y.o.)