belgravia
dental studio

# Health questionnaire

## Dear patient!

Please, fill in this questionnaire accurately. The information you provide is essential for an adequate and safe dental treatment and for the good prognosis.

**Your Last name, First name, and Patronymic** _____
_____

**Date of birth** _____

**1.** Do you have or did you have any of these diseases/conditions:
- ☐ Cardiovascular disorders (if yes, which ones)
- ☐ Allergic reactions (if yes, what causes it and how it appears)
- ☐ Clotting disorders
- ☐ Infectious diseases (HIV, hepatitis C)
- ☐ Other health problems that you are aware of:_____

**2.** Are you currently taking any medications?
If yes, which ones _____
_____

**3.** For women:
- ☐ Are you pregnant?
- ☐ Are you breast-feeding?

**4.** I would like to add the following about my health:
_____
_____
_____

**E-mail:** _____

**Mobile phone:** _____

Date _____ Signature_____ / _____/

Patient record number (filled in by the clinic's staff) _____