DUODENT BIELANY

LAST NAME		**Please indicate how you learned about our Dental Clinic**	
FIRST NAME			
DATE OF BIRTH		**Recommendation from friends/familu**	
PESEL / ID		**Advertisement on Facebook**	
ADDRESS		**Advertisement on the street**	
		Internet (Google, website: www.duodent.com.pl)	

MEDICAL CONSIDERATIONS

Does the patient suffer from any of the following conditions:

Undesirable reaction to any of the following substances: ☐Aspirin ☐Ibuprofen ☐Paracetamol ☐Codeine ☐Penicillin ☐Erythromycin ☐Tetracycline ☐Sulfonamides ☐Rubber, latex ☐Local anesthetic ☐Metals (nickel, gold, silver, others: .....) ☐Other:	YES	NO	Has the patient been treated for or exposed to any serious infectious diseases in the past two years?	YES	NO
			Does the patient have any planned surgical procedures within the next 18 months?		
Cardiovascular diseases			Thyroid disorders		
Infectious endocarditis			Weakened immune system		
Lung diseases			Kidney disorders		
Cured tumor or malignant neoplasm			Liver disorders		
Artificial valve			Neurological disorders		
Diabetes			Epilepsy (seizures)		
Coagulation disorders / Bleeding disorders			Viral infection of the oral cavity (e.g., herpes)		
Tumor or other malignancy currently under treatment			Other disorders (If yes, please specify: .....)		
Treated heart condition			**Whether:**		
Cardiac pacemaker / implanted defibrillator			Do you experience mouth inflammations or gum bleeding?		
Blood clots or blockages			Did your parents have or have periodontal disease?		
Anemia			Do you smoke cigarettes or have you smoked in the past?		
Recent heart attack within the past 6 months			FEMALE – Are you taking contraceptive measures?		
Osteoporosis / Osteopenia			FEMALE – Are you currently pregnant?		
Rheumatoid arthritis			**RECEIVED MEDICATIONS**		
Artificial prostheses (e.g., joints)			**Name of medication**	**Reason for taking**	
Radiation therapy / Chemotherapy within the past 12 months					
Hepatitis B or C infection					
HIV / AIDS					

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Patient's Signature