FDI HEALTH QUESTIONNAIRE

Patient personally fills out the form by circling YES or NO. Additional clarification and info are available on request.

Submitted personal data is confidential and protected; patient's identity will not be available to public in any form. By signing, I hereby agree that all the data and supporting materials (photos, x-rays, 3D scans, etc.) may be used for medical, scientific, professional or educational purposes.

Questionnaire filled out on (date)			Sex: ☐ F ☐ M
LAST NAME	FIRST NAME	ID Number	DATE OF BIRTH
Address		Occupation and place of work	
Phone	Mobile	E-mail	
How did you learn about polyclinic	a) web b) referral c) social media d) other		
Main reason for visit			
Name, address, and contact info of next of kin			

PLEASE ANSWER ALL QUESTIONS

I give my consent to receive medical and related documents via e-mail.	NO	YES
I give my consent to be contacted via phone number(s) and e-mail(s) I provided willingly.	NO	YES
I want to receive info on new services and special offers.	NO	YES
Are you suffering from any medical condition?	NO	YES
If YES, from what?		
Have you been treated during the last two years?	NO	YES
If YES, for what?		
Name and contact info of your GP		
Have you been hospitalized during the last two years?	NO	YES
Which medicine are you taking - occasionally or constantly?		
Have you, or any member of your family, had any complications from local or complete anesthesia?	NO	YES
Are you allergic to any medicine and/or anything else?	NO	YES
Have you ever experienced problems with blood clotting?	NO	YES
Have you ever been exposed to radiation of head or neck (X-ray not included)?	NO	YES
Do you have any infectious diseases?	NO	YES
Are you a smoker? If YES, how heavy?	NO	YES
Are you HIV positive?	NO	YES
Are you addicted to drugs? If YES, what drugs?	NO	YES
FOR WOMEN		
Are you pregnant?	NO	YES
If YES, what is your estimated date of delivery?		

MARK MEDICAL CONDITIONS YOU HAVE OR USED TO HAVE

☐ Heart valve damage	☐ Endocarditis	☐ Epilepsy	☐ Allergic disorders
☐ Congenital heart defects	☐ Persistent cough	☐ Increased gland size	☐ Viral hepatitis
☐ Bronchiectasis	☐ TBC (tuberculosis)	☐ Gastrointestinal ulcer	☐ Asthma
☐ Thyroid gland diseases	☐ Arthritis	☐ High blood pressure	☐ Leukemia
☐ Diabetes	☐ Artificial heart valves	☐ Anemia	☐ Oral candidiasis
☐ Sinusitis	☐ Pacemaker	☐ Glaucoma	☐ Jaundice
☐ Malignant tumor (cancer)	☐ Psychiatric treatment	☐ Venereal diseases	☐ Pulmonary phlegm

Please indicate any other diseases not on this list:

PATIENT SIGNATURE	VERIFIED BY DOCTOR

In handling personal data we comply with all regulations set by General Data Protection Regulation (GDPR) and we respect all rights of the respondent in accordance with GDPR.

We are familiar with the obligation to notify AZOP supervisory body, and all relevant subjects, in case that protected data is compromised or discovered by a third party, within 72 hours.