

Title, name and surname:

Date of birth: Height in cm: Weight in kg:

Please, answer all the following questions:

1. Are you currently going through any cold or infectious disease? Yes
No

If yes, give further details

2. Have you been examined by any doctor recently? Yes No

If yes, by which doctor and for what disease.....

3. What medications are you currently taking on a regular basis?

4. Have you ever had any surgery? Aesthetic operations too! Yes No

Give the type and date of the surgery

5. Have you had general anaesthesia or analgesic sedation? Yes No

6. Where there any complications? Yes No

If yes, describe them.....

7. Have you ever had a blood transfusion? Yes No

8. Are you treated for any heart disease? Yes No

Myocardial infarction, month/year.....

Valves disease, heart arrhythmia, stent.....

9. Are you treated for high blood pressure? Yes No

10. Do you suffer from vascular disease? Yes No

11. Do you suffer from lungs or airways disease? Yes

No

E. g. asthma, chronic bronchitis, tuberculosis.....

12. Do you suffer from muscle disease or muscle weakness? Yes No

13. Do you suffer from liver disease, e. g. hepatitis, cirrhosis?

Yes No

14. Do you suffer from kidney disease, e. g. repeated inflammation, kidney stones?

Yes No

15. Do you have diabetes? Yes
No

What do you take for decreasing blood sugar level?.....

16. Do you suffer from any neurological disease? E. g. epilepsy, paralysis
Yes No

Have you had cerebrovascular accident? Yes No

17. Do you suffer from mental disease? E. g. depression, schizophrenia
Yes No

18. Do you suffer from blood disease?

E. g. coagulation disorder, frequent bruise occurrence
Yes No

19. Do you take blood thinning medications? Yes
No

If yes, give further details.....

20. Do you suffer from allergy?
Yes No

Food allergy - give types of food.....

Medication allergy - give the names:

Other substances - give the names.....

21. Do you have another disease you have not stated yet?
Yes No

If yes, give further details.....

22. Do you wear removable denture?
Yes No

23. Do you have teeth disorder? E. g. loose teeth, tooth decay
Yes No

If yes, give further details.....

24. Do you smoke? Yes No

How many cigarettes per day?.....

25. Do you drink alcohol? no occasionally
regularly.....

26. Do you take sleeping pills?
Yes No

If yes, give further details.....

27. For women only: Do you take hormonal contraception or hormonal substitution?
Yes No

Give other health problems or other details you think we should be informed about:

.....

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28. Have you been vaccinated against Covid 19?
Yes No

If yes, what you were vaccinated with.....

How many doses

When was the last dose given?

Date:

Signature: