Nordland FYLKESKOMMUNE
Tannhelsetjenesten

Tannklinikk
stempel

HEALTH QUESTIONNAIRE

Name	Date
Date of birth / personal ID no.	Profession/school/working place:
Address	
Private Phone no.	Phone no. at work / Mobile telephone
E-mail:	
Parents/guardian:	

Generelle opplysninger

- ☐ Cardiovascular disease
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Immunity disease
- ☐ Jaundice (Hepatitis)
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Psychic problems
- ☐ Radiation treatment head/neck
- ☐ Diet
- ☐ Complication after dental treatment
- ☐ Smoker
- ☐ Asthma
- ☐ Haemophilia
- ☐ Eating disorders
- ☐ HIV/AIDS
- ☐ Pneumonia
- ☐ Stroke
- ☐ Parkinson's disease
- ☐ Cancer
- ☐ Rheumatic disease
- ☐ Other

- ☐ Reduced vision
- ☐ Reduced hearing
- ☐ Reduced voice capability
- ☐ Reduced mobility

Allergy/hypersensitivity

- ☐ Penicillin
- ☐ Local anaesthesia
- ☐ Pollen
- ☐ Food
- ☐ Nickel
- ☐ Latex
- ☐ Other

Mouth/teeth

- ☐ Gingival bleeding
- ☐ Foul breath
- ☐ Often wounds in the mouth
- ☐ Dry mouth
- ☐ Teeth-grinding
- ☐ Painful chewing muscles
- ☐ Finger sucker
- ☐ Mouth breather
- ☐ Other
- ☐ No remarks

☐ Obs! i helseskjema

Medicamentation - preparation and doses

Doctor

☐ Treatment last two years

Patient's evaluation of health condition

☐ Good ☐ Average ☐ Bad

Pregnant, term:

Last dental treatment

Other/ additional information

Why is the patient coming?

Signature