GENERAL HEALTH FORM

All disclosed information is covered by doctor-patient confidentiality and used to ensure your safety. Please, provide accurate answers to the following questions. Should you have trouble answering a question, please skip it and **discuss your doubts with the doctor.** The following questions will be used to select the appropriate course of treatment and the best anesthetic before the procedure.

……..……………………………………..…………………………. PESEL | | | | | | | | | | | |

Patient name and last name

Telephone no. …………………………………

Address……………….…………………………………………………………….

Do you feel healthy overall? YES ☐ NO ☐

Were you hospitalized in the past two years? YES ☐ NO ☐

If so, what was the reason: ………………………………………………………………………….

Are you currently treated for any disease? YES ☐ NO ☐

If so, what kind: ………………………………………………………………………………………..

Do you currently take any medication? (especially aspirin, anticoagulants) YES ☐ NO ☐

If so, what kind: ……………………………………………………………………………………...…….

Do you have any allergies? YES ☐ NO ☐

If so, what kind: ………………………………………………………………………………………..

Do you experience:

shortness of breath	TAK ☐ NIE ☐	swelling	YES ☐ NO ☐
hives	TAK ☐ NIE ☐	itchiness	YES ☐ NO ☐

Do you bleed easily? YES ☐ NO ☐

Have you experienced episodes of fainting or loss of consciousness? YES ☐ NO ☐

Do you have a heart pacemaker? YES ☐ NO ☐

Do you suffer or have you ever suffered from any of the following?

heart diseases (heart attack, coronary artery disease, heart defects, arrhythmias, myocarditis) YES ☐ NO ☐

other circulatory diseases (hypertension, hypotension, fainting, shortness of breath) YES ☐ NO ☐

blood vessel diseases (varicose veins, phlebitis, bad blood circulation in the limbs, leg pain while walking) YES ☐ NO ☐

lung diseases (emphysema, pneumonia, tuberculosis asthma, chronic bronchitis) YES ☐ NO ☐

digestive tract diseases (stomach and duodenal ulcers, intestinal disease) YES ☐ NO ☐

liver diseases (liver stones, hepatitis, cirrhosis) TAK ☐ NIE ☐

urinary tract diseases (kidney inflammation, kidney stones, urination problems) YES ☐ NO ☐

metabolic diseases (diabetes, gout) YES ☐ NO ☐

thyroid diseases (hyperthyroidism, hypothyroidism, nontoxic goiter) YES ☐ NO ☐

nervous system diseases (epilepsy, paresis, consciousness loss, paralysis, dysesthesias, myasthenia gravis) YES ☐ NO ☐

bone and joint diseases (root pain, degenerative changes in the spine and joints, fractures) YES ☐ NO ☐

blood and coagulation diseases (hemophilia, anemia, hemorrhages, nosebleeds, prolonged bleeding after tooth extraction) YES ☐ NO ☐

eye diseases (glaucoma) YES ☐ NO ☐

mood changes (depression, neurosis) YES ☐ NO ☐

infectious diseases YES ☐ NO ☐

hepatitis A	YES ☐ NO ☐	AIDS	YES ☐ NO ☐
hepatitis B	YES ☐ NO ☐	tuberculosis	YES ☐ NO ☐
hepatitis C	YES ☐ NO ☐	STDs	YES ☐ NO ☐

rheumatic disease YES ☐ NO ☐

osteoporosis YES ☐ NO ☐

other diseases which? ……

What was your last measured blood pressure? ……

Have you ever had surgery? YES ☐ NO ☐

If so, when and why: ……

Did you tolerate the anesthesia well? YES ☐ NO ☐

Have you had a blood transfusion? YES ☐ NO ☐

If so, when and why: ……

Do you smoke? YES ☐ NO ☐

If so, how much and since when: ……

Do you consume alcohol? YES ☐ NO ☐

Do you use sedatives, sleeping pills or drugs? YES ☐ NO ☐

If so, what kind: ……

Questions for women:

Are you currently pregnant? YES ☐ NO ☐

If so, in which month: ……

When was your last period? ……..

Do you use oral contraceptives? YES ☐ NO ☐

PATIENT (LEGAL GUARDIAN*) DECLARATION

I confirm that the above information is correct. I agree to report any health changes at the first visit after they occur.

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I, ……..... PESEL no.: | | | | | | | | | | | |

Imię, nazwisko

resident in: ..……..……, declare that **I authorize*** Mr/Ms ……....., personal ID card no....., / **I do not authorize any person*** to receive my (my charge's*) health information and, in the event of death, to have access to my (my charge's*) medical records, as well as duplicates, extracts, and copies of these records kept at

……

I know my rights as defined in the Patient Rights Charter and grant my consent to the treatment at this clinic. The consent covers all procedures recommended by and agreed upon with the lead doctor and other doctors at the clinic.

…… ……..……

date *patient (legal guardian*) signature*

* delete as appropriate

The Patient Rights Charter can be consulted on the premises.