

**Naam:**..... **Geboortedatum:**.....

Has anything changed in your health in the past few months?	Yes/No If yes, what?
Are you allergic to anything?	Yes/No If yes, what?
Did you ever have a heart attack?	Yes/No if yes, when?
Do you suffer from palpitations?	Yes/No
Are you being treated for high blood pressure?	Yes/No If yes: upper pressure:      under pressure:
Do you have chest pain with exertion?	Yes/No
Do you get short of breath when you lie flat in bed?	Yes/No
Do you have a heart valve deficiency or an artificial heart valve?	Yes/No
Do you have a congenital heart defect?	Yes/No
Have you ever experienced endocarditis?	Yes/No
Do you have a pacemaker (or icd ) or neurostimulator?	Yes/No
Have you ever passed out during dental or medical treatment?	Yes/No
Do you have epilepsy?	Yes/No
Have you ever had a brain haemorrhage or stroke (or TIA)?	Yes/No
Do you suffer from lung complaints such as asthma, bronchitis or chronic cough?	Yes/No
Do you have diabetes?	Yes/No If yes: do you use insulin?
Do you have anemia?	Yes/No
Have you ever had prolonged bleeding after tooth extraction or surgery?	Yes/No
Do you have hepatitis, jaundice or other liver disease?	Yes/No
Do you have kidney disease?	Yes/No
Do you have rheumatism or chronic joint complaints?	Yes/No
Have you been irradiated because of a tumor in your head or neck?	Yes/No
Do you smoke?	Yes/No If yes: how much a day?
Women: are you pregnant?	Yes/No
Women: are you breastfeeding?	Yes/No
Do you have an illness or condition that has not been asked about	Yes/No If Yes, which illness?
Have you used a medicine in the past against osteoporosis (a bisphosphonate or denosumab)	Yes/No
Are you taking any medicines?	Yes/No If yes: which medication?