Patient sticker

F2011: Medical questionnaire

Without a **LETTER OF REFFERAL**, no treatment will be performed.

Do you use medication? Please bring a **MEDICATION OVERVIEW** from your pharmacy. This overview should not be older tan 2 weeks.

Please arrive **15 MINUTES** in advance for registration and possible X-ray.

Please answer this questionnaire ON EITHER SIDE and bring it with you to your next appointment.

- Do you have a medical condition or illness? Yes / No

  If yes which one? _____

  _____

- Do you use medication or blood thinners? Yes / No

  If yes which one? _____

  _____

- Are you allergic to medication, antibiotics or latex? Yes / No

  If yes which one? _____

- Do you smoke? If so, how much? _____ Yes / No
- Did you ever undergo surgery? Yes / No

  If so what? _____

- Do you have a contagious disease such as Hepatitis B / HIV / otherwise? Yes / No

  If yes which one? _____

- Do you have a bleeding disorder? Yes / No

  If yes which one? _____

- Have you been diagnosed with facial pain / neuropathic pain by a doctor? Yes / No

If yes, which one? _____

- Have you ever been treated with radiotherapy? Yes / No
- Are you pregnant? Yes / No
- Are you breastfeeding? Yes / No

BRMO/MRSA

BRMO stands for Resistant Micro-organisms. All bacteria that no longer respond to the most commonly used antibiotics are called BRMO. The most known BRMO is the MRSA, better known as the hospital bacterium. MRSA poses a serious risk for people with a reduced resistance. People can carry this bacterium without being ill but infect others.

- Do you, your close family or partner have BRMO or the MRSA-bacterium? Yes / No
- Do you work or live on a farm where large-scale live cattle are kept? Yes / No
- Have you been treated in a Dutch hospital for the past 2 months? Yes / No
- Have you been living in an asylum center for the past 2 months? Yes / No
- Have you been treated in a foreign hospital during the past year? Yes / No

I hereby declare that I have completed both sides of this medical questionnaire truthfully.

Signature: _____ Date: _____

I Hereby give permission to the Hague Clinics to provide my medical and dental data including any x-rays to dentist/GP/specialist by email or post.

Signature: _____ Date: _____

Please remove any EARRINGS, NECKLACE, and / or PIERCINGS in the head and neck area at home.

This is required for X-rays.

For any questions or contact:

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