

Patient's

Name: Surname:

1. Are you currently receiving any treatment?
2. Do you take any medications?
3. Do you have or used to have any disease?
4. Mark the diseases you have listed below.

Heart diseases □ Diabetes □

Blood pressure problem □ Epilepsy (epilepsy) □

Rheumatoid fever □ Rheumatoid arthritis □

Goiter (Troid Tablets) □ Blood diseases □

Allergy (Drug, food, etc.) □ Venereal (skin) disease □

Jaundice □ Asthma, hay fever □

Kidney liver disorders □ Lung diseases □

Sinusitis □ Cancer diagnosis □

Infectious diseases (Hepatitis, AIDS, etc.) □

1. Have you received radiotherapy in the head and neck area?
2. Have you had chemotherapy?
3. Does your bleeding last long after surgical intervention or injury?
4. Do you have any other medical problems?
5. Do you have a doctor that you are constantly under control?
6. For women; pregnancy status:

I confirm the accuracy of the above information
Name, surname :

Date:

Signature:



