Health questionnaire

Name: _____ First name: _____

Date of birth: _____ Age: _____

Address: _____ City: _____ Postal code: _____

Tel. Home: _____ Tel. Work: _____ Cell. :_____

Email: _____ Occupation: _____

How were you referred to the clinic?

□ Reference (name of the patient): _____

□ Website □ Publicity □ other: _____

Reason for your consultation ?

☐ Prevention ☐ Relief ☐ Correction

1. Which are your major symptoms (by order of importance)? And what caused your symptoms?

I. _____

II. _____

III. _____

2. Since when do you have these symptoms?

I. _____

II. _____

III. _____

3. How did these symptoms appear?

I. ☐ Accident ☐ Gradually ☐ Suddenly ☐ I do not know

II. ☐ Accident ☐ Gradually ☐ Suddenly ☐ I do not know

III. ☐ Accident ☐ Gradually ☐ Suddenly ☐ I do not know

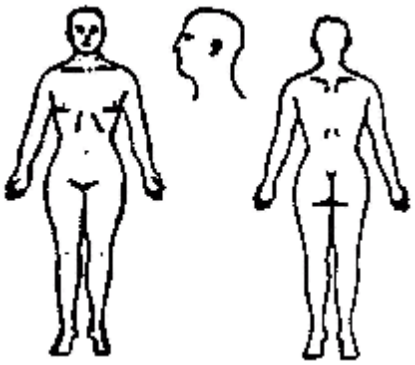
4. How do your symptoms progress?

I. ☐ Stable ☐ Improve ☐ Worsen

II. ☐ Stable ☐ Improve ☐ Worsen

III. ☐ Stable ☐ Improve ☐ Worsen

5. Please indicate the painful areas on the diagram below:



6. Your main symptom is present:

☐ 100% of time ☐ 75% ☐ 50% ☐ 25% ☐ - of 25% of time

7. Your main symptom is worse:

☐ In the morning ☐ During the day ☐ In the evening ☐ At night

8. Your symptoms are worse in which position or movement?

☐ Sitting ☐ Lying down ☐ Upright ☐ Leaning ☐ Turning your head

☐ Other (describe): _____

9. Check the box which corresponds to the intensity of your main symptom :

No pain ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Extreme pain

HEALTH HISTORY:

10. Family diseases and/or history:
_____

11. Medication:
_____

12. Surgeries (year):
_____

13. Hospitalizations (year):
_____

14. Accidents (car, work) /Falls /Fractures (year):
_____

15. What is the name of your MD.:
_____

16. Did you get an X-ray or an MRI in the last 3 years? □ yes □ no

If so, which parts of your body:
_____

17. Have you ever had these symptoms before? ☐ Yes ☐ No

18. Did you consult a health professional for this problem? ☐ Yes ☐ No

Details: _____

19. Do you use: ☐ orthodontic retainer ☐ visual correction ☐ hearing aids ☐ orthopedic footwear

Declaration

I declare that all information provided above is complete and exact. I authorize the professional of TAGMED clinic to carry out on my person a physical examination. I assume the responsibility of the cost.

Signature : _____ Date : _____