NAME SURNAME

ADDRESS COUNTRY

PHONE NUMBER DATE OF BIRTH : …. / …. / …..

MEDICAL QUESTIONNAIRE

Surround your answer

1) Do you suffer from heart disease (high blood pressure…) YES NO

2) Do you take anticoagulant medecines? YES NO
Which ones ?.....

3) Are you diabetic ? YES NO

4) Do you have an ulcer? YES NO

5) Do you have lung problems? YES NO

6) Did you suffer from acute articular rheumatisms ? YES NO

7) Do you have osteoporosis ? YES NO

8) For women : are you pregnant ? YES NO

9) Do you or did you have chemoradiotherapy?

10) Do you have a viral hepatitis ? YES NO

11) Are you seropositive ?

12) Do you suffer from anxiety disorder ? YES NO

13) Do you have allergic responses :
With medecines ? (penicillin, aspirin …) YES NO
With metal? YES NO

14) Did you have problems with anaesthesia ? YES NO

15) Actually do you take medecines ? YES NO
Which ones ?.....
…….

16) Do you have something more to tell us about your health ? YES NO
…….
…….

I attest that all these informations are correct.

Made in Sarlat, …… Signature