|  |  |
| --- | --- |
| **Patient Info 1** | **Referring Doctor Info 1, 2** |
| **Full name** | **Full name** |
| **Sex / Age** | **Specialty (Specialization)** |
| **Home address** | **Clinic address**  |
| **Phone /** **Ε-mail** | **Phone / Ε-mail** |

**Patient Evaluation Form**

**1 Please send relevant medical examinations and diagnostic imaging.**

**2 To be completed if referred by the Doctor. We will contact you as soon as possible after the examination - evaluation of the patient.**

|  |
| --- |
| **Medical History****(if existing disease please give details)** |
| **Cardiovascular**  | **Endocrinopathies** |
| **Respiratory**  | **Infectious diseases** |
| **Gastrointestinal** | **Autoimmune diseases** |
| **Hematopoietic** | **Other** |
| **Musculoskeletal** | **Smoking (cigarettes / day and duration)** |
| **Skin diseases** | **Alcohol (drinks / day and duration)** |
| **Psychiatric diseases** | **Medication** |
| **Diabetes mellitus** |
| **Allergies** |

|  |
| --- |
| **Reason for Referral****(please give details)** |
| **Ulceration**  | **Oral pigmented spots** |
| **White / Red lesions**  | **Burning / Stinging** |
| **Xerostomia** | **Blister** |
| **Altered taste** | **Impacted / Semi – impacted 3rd molar** |
| **Oral soreness**  | **Implant placement** |
| **Lump** | **Apicoectomy**  |
| **Aphthae** | **Sinus lift** |
| **Oral malodor** | **Other** |
| **Duration of lesions / symptoms****Similar conditions in the past ?****Any treatments already applied for this reason ?****Have you seen any other Doctors for this problem ?** |



**Mark the area of the lesion / symptoms in the diagram.**

**Date**

**Full name / Signature**

Fill in the form and send it by e-mail to titsinidess@yahoo.com or as an accompaniment during the examination at the Clinic