



Approved by: Medical Director of Dentistry
 In force since: 01.08.2019
 Version number: 1

Healthcare facility stamp

EPIDEMIOLOGICAL INTERVIEW
concerning the risk of being infected with HBV, HCV viruses
 (concerns the period of 6 months before being admitted to hospital)

Idx no.,	Health record no.
Surname and name	PESEL no.
Address	

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Has she/he suffered from hepatitis, jaundice?
If yes, when? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has she/he been treated in other Health Care clinics?
including private clinics?
If yes, where?
If yes, when? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has she/he had contact with people suffering from hepatitis B, hepatitis C?
If yes, where? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has she/he received injections, drips, transfusions? *
If yes, where?
If yes, when? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has she/he undergone proceedings which injure layers of skin
(biopsies, punctures, acupuncture, surgeries, blood collections)?
If yes, where?
If yes, when? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has she/he been vaccinated against hepatitis B?
If yes, how many times? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Was she/he assessed with reference to HBs antigen and anti-HCV antibodies? <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has she/he undergone endoscopic examination?
If yes, where?
If yes, when? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has she/he used services of dentist clinics?
(teeth extraction, fillings, removal of scale)
If yes, where?
If yes, when? | <input type="checkbox"/> | <input type="checkbox"/> |





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- | | Yes | No |
|--|--------------------------|--------------------------|
| 10. Has she/he used services of oculists?
If yes, where?
If yes, when? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has she/he used hairdresser's services, beauty clinic services (manicure, pedicure, tattoo, ears piercing, razor shaving, etc.)
If yes, where?
If yes, when? | <input type="checkbox"/> | <input type="checkbox"/> |

.....
(legible signature of the interviewing person)

.....
(Patient's legible signature)

* underline appropriate

.....
(for minor patients aged 16-18 parallel consent
of the legal guardian)

