



PATIENT HISTORY FOR DENTAL AND ORAL CARE

To ensure patient safety, your dentist needs information about any illnesses and medications you may currently have. The information will be treated as confidential.

Name _____ Identity code _____ - _____

Profession and place of employment _____

Home address _____

Postal code _____

Telephone, home _____ work _____ cell phone _____

E-mail address _____

I am a veteran/deminer

GENERAL HEALTH

How would you characterise your current health? _____

Do you have or have you had any of the following conditions?

- Allergy (medicines, foodstuffs, rubber), please specify. _____
- Heart or vascular condition
 - myocardial infarct
 - pacemaker
 - valve disorder
 - cardiac valve prosthesis
- Cerebral infarction
- Elevated blood pressure
- Blood disease, anaemia
- Bleeding tendency
- Diabetes
- Respiratory disease, asthma
- Intestinal disease
- Musculoskeletal disorder
- Rheumatic disease
- Osteoporosis
- Renal disease
- Liver disease, hepatitis
- Thyroid disease
- Cancer
- Neurological disease, epilepsy
- Recurrent headache
- Mental disorder
- Poor vision or hearing
- Blood-transmitted disease
- MRSA, VRE, or equivalent hospital-associated infection
- HIV
- Other illness, please specify. _____

Additional information that you would like to share: _____

- I take medication regularly. Please specify. _____
- _____
- _____
- _____
- _____

- I am pregnant, expected date of delivery _____
- I have received radiation therapy on my neck or head area.
- I have a joint prosthesis, ventricular prosthesis or other artificial implants.
- I have received an organ transplant.

Have you experienced side-effects due to local anaesthesia? Please specify. _____

SMOKING AND USE OF SUBSTANCES

Smoking and use of substances have an effect on oral health.

- I smoke cigarettes or use snuff _____ times/day.

How often have you used alcohol in the past 12 months?

- 6 to 7 times/week 3 to 5 times/week twice/week once/week
- a couple of times/month less frequently I have not used alcohol in the past 12 months

DENTAL AND ORAL HEALTH

Reason for seeking treatment: _____

When have you last had a full dental/oral check? _____

When have you last received dental/oral treatment? _____

Have there been any problems in your dental care? Please specify. _____

How often do you brush your teeth?

- twice a day minimum once a day less frequently

How often do you clean between your teeth?

- once a day minimum a couple of times/week 1 to 2 times/week less frequently

Which of the following best describes your eating habits?

- I eat 4 to 6 healthy and regular, planned meals a day.
- I eat 2 to 3 healthy and regular meals a day.
- I eat 2 to 3 irregular meals a day and have snacks between meals.
- I eat irregularly and have snacks during the day.

When I am thirsty, I drink _____

I drink daily

- soft drinks / juices sports/energy drinks other sweet/acidic drinks

I am on a special diet. Please specify. _____

Information according to Personal Data Act (523/99)

The information you have provided will be stored in a patient register maintained by

- a) the dentist
- b) the dental centre (centralised register, see below).

Consent for release of patient information

- I give my consent that my patient information can be stored in a centralised patient register.

The register is maintained co-operatively by the dental centre and its dentists who participate in centralised collection of patient information. Your patient information is confidential. With your consent, the dental centre can use this information in matters relating to your treatment. The information will be released only with your permission or if required by law. You have the right to examine your patient information stored in the register. For additional information, see the register description/information form provided by the dental centre.

_____/_____
Date

Signature