PATIENT HISTORY FOR DENTAL CARE

The information will be treated as confidential and it helps in planning your treatment.

Name _____ Identity code _____

Adress _____ Profession, place of employment _____

Postal code, City _____ Tel. Home _____ Work _____

e-mail _____ GSM _____

	Yes	No
Is your current health good?	☐	☐
Do you get regular medical treatment?	☐	☐
What? _____		
Do you use any medication regularly? Which?	☐	☐
_____		
Are you allergic to any medicine or substance?	☐	☐
(ex. penicillin,sulfa, aspirin, iodid, latex)		
Which? _____		
Have you had any problems with local anesthesia?	☐	☐
Are you pregnant?	☐	☐
Have you had radiation therapy on neck or head area?	☐	☐

Do you have/have you had any of the following conditions

- Heart or vascular condition ☐
- Elevated blood pressure ☐
- Rheumatic disease ☐
- Blood disease, anemia ☐
- Bleeding tendency ☐
- Diabetes ☐
- Respiratory disease, asthma ☐
- Thyroid disease ☐
- Rheumatoid arthritis ☐
- Renal disease ☐
- Liver disease, hepatitis, HIV ☐
- Osteoporosis ☐
- Neurological disease, epilepsy ☐
- Poor vision or hearing ☐
- Cancer ☐
- Mental disorder ☐
- Intestinal disease ☐
- Muscuolskeletal disorder ☐
- Other illness, please spesify ☐

_____

	Yes	No
Do you have, artificial joint, pacemaker, valve disorder or cardiac valve prosthesis	☐	☐
Have you had inflammations or any disease in mouth, throat,head or head area?	☐	☐

Do you have any of the following symptoms

- Pain in face, temporomandibular joints or difficulties when opening mouth ☐
- Clicking or brawl in temporomandibular joints ☐
- Tenderness when biting ☐
- Bleeding from the gums ☐
- Dry mouth ☐
- Suun tai kielen arkuutta tai kirvelyä ☐
- Toothache ☐
- Shooting pains cold/hot/sweet ☐
- Recurrent headache ☐

How often do you brush / clean

teeth	2 /day ☐	1 / day ☐	rarely ☐
tooth pitches	1/day ☐	1-2 / week ☐	rarely ☐

	Yes	No
Do you smoke or use snuff	☐	☐
Do you use soft- sport- or energy drinks	☐	☐
Do you eat snacks regularly / often?	☐	☐
Do you have fear for dental treatment?	☐	☐
Do you want local anesthesy during the treatment?	☐	☐

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

_____

Reason for seeking treatment:

_____

_____

_____

Additional information that you would like to share:

_____

_____

_____

Information according to Personal Data Act (523/99)

The information you have provided will be stored in a patient register maintained by the dental centre. 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 permissionor if required by law. You have the right to examine your patient information stored in the register.

Date ____ / ____ 20 _____

Signature

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