Rady Faculty of Health Sciences | University of Manitoba

MEDICAL HISTORY

NAME:

Please answer the following questions as accurately as possible. Circle yes or no, if you are not sure of the answer put a question mark next to the question.

DENTAL HISTORY

Dentist's: Dr. Tom Swanlund

Name/ Address: Aqua Dental Wellness 1565 Regent Ave

Phone: 204-663-3423

Date of last dental appointment: Jan 14, 2021

1. Do you have regular dental appointments? (Yes) No
2. Have you had any trouble with previous dental treatments? Yes (No)
3. Do you think saving your teeth is a waste of time? Yes (No)
4. Do you have any lumps or sores in your mouth now? Yes (No)
5. Have you ever had lumps or sores in your mouth before? Yes (No)
6. Do you have pain in the teeth, jaws, or head? Yes (No)
7. Have you ever had pain in your teeth, jaws or head? Yes (No)
8. Are there any dental problems that run in the family? (Yes) No

MEDICAL HISTORY

9. Have you ever had any problems with your heart or blood vessels? Yes (No)
10. Do you get chest pain? Yes (No)
11. Have you ever had rheumatic fever? Yes (No)
12. Do you have high blood pressure? Yes (No)
13. Have you ever been told you have an abnormal sound in your heart? Yes (No)

14. Do you have a pacemaker or defibrillator? Yes (No)
15. Have you ever had tuberculosis or emphysema? Yes (No)
16. Have you ever had asthma or hay fever? Yes (No)
17. Do you get shortness of breath when lying down or when climbing stairs Yes (No)
18. Do you have problems with your bowel movements? Yes (No)
19. Have you gained or lost weight recently? Yes (No)
20. Have you ever had hepatitis? Yes (No)
21. Do you have HIV/ AIDS? Yes (No)
22. Have you ever had ulcers of your stomach or intestines? Yes (No)
23. Have you ever had thyroid problems? (Yes) No
24. Have you or any member of your family had diabetes? Yes (No)
25. Are you pregnant? Yes (No)
26. Have you ever had any kidney or bladder problems? (Yes) No
27. Have you ever had any trouble with your glands? Yes (No)
28. Have you ever had syphilis, gonorrhea or any other venereal disease? Yes (No)
29. Have you ever passed blood in your urine? Yes (No)
30. Have you ever bled excessively following tooth extraction or a cut? Yes (No)
31. Have you ever had a blood transfusion? Why? Yes (No)
32. Are you on blood thinners? Yes (No)
33. Have you ever had problems with your blood? Yes (No)
34. Do you have frequent fractures of dislocations of bones? Yes (No)
35. Have you ever had joint replacement surgery? Yes (No)
36. Do you have any joint or muscle pain? Yes (No)
37. Do you suffer from frequent or severe headaches? Yes (No)
38. Have you ever had problems with local or general anesthesia? Yes (No)
39. Have you ever taken medication for an emotional problem? Yes (No)
40. Have you or anyone in the family ever had fits, seizures, or convulsions? Yes (No)
41. Have you ever had a skin disease? Yes (No)
42. Do you have any eye problems? Yes (No)
43. Do you have any ear problems? Yes (No)
44. Do you have any nose problems? Yes (No)
45. Do you have any allergies? Yes (No)
46. Have you ever had any unusual reactions to medical treatment? Yes (No)

47. Are there any diseases or medical problems that run in the family? (Yes) No

48. Do you smoke or drink? Yes (No)

49. Have you ever been hospitalized? Yes (No)

50. Are you taking any prescription medications or non-prescription drugs? (Yes) No

COMMENTS ON ANY OF THE QUESTIONS:

(Please indicate reason for any "YES" answers for #'s 2 – 51)

8. Periodontitis (neglected dental care)

23. Hyperthyroid (May 2019) - Mild, stable, controlled with medication

26. Bladder infection (Jan 2020)

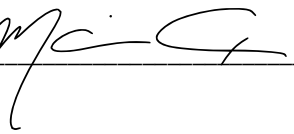
47. High blood pressure (mother's side)

50. methimazole, Tri-Cyclen Lo

BLOOD PRESSURE: (to be taken day of Workshop)_____

I have reviewed the Dr. Gerald Niznick College of Dentistry, infection prevention and control material and am prepared to implement the procedures outlined in the course content in a safe manner

NAME: Monica Axalan

SIGNATURE: 

DATE: March 11, 2021