



MEDICAL HISTORY

NAME: Kara Leckie

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. Scott Leckie

Name/ Address: 3278 Portage Avenue

Phone: 204 958 4444

Date of last dental appointment: Feb. 2/21

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

MEDICAL HISTORY

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| 9. Have you ever had any problems with your heart or blood vessels? Yes | <input checked="" type="radio"/> No | <input type="radio"/> Yes |
| 10. Do you get chest pain? | <input type="radio"/> Yes | <input checked="" type="radio"/> No |
| 11. Have you ever had rheumatic fever? | <input type="radio"/> Yes | <input checked="" type="radio"/> No |
| 12. Do you have high blood pressure? | <input type="radio"/> Yes | <input checked="" type="radio"/> No |
| 13. Have you ever been told you have an abnormal sound in your heart? | <input type="radio"/> Yes | <input checked="" type="radio"/> No |

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

◦ Sulfa allergy

◦ drink socially

◦ taking birth control pill. (YAZ)

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: Kara Leckie

SIGNATURE: KLeckie

DATE: march 8, 2021