Rady Faculty of Health Sciences | University of Manitoba

MEDICAL HISTORY

NAME: Michelle Danis

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. Orloff.

Name/ Address: 3278 Portage Ave, Assiniboine Dental group

Phone: _____

Date of last dental appointment: April 5 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)

6/7 -> TMJ pain
24 -> Diabetes - brother, grandmother type 2
45 -> Penicillin allergy
47 -> Diabetes, potentially Non-Alcoholic Liver disease

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: Michelle Danis

SIGNATURE: _____

DATE: April 19 2021