ETELÄ-KARJALAN hyvinvointialue

PRELIMINARY INFORMATION FOR DENTAL CARE

Confidential

Information provided is confidential and is used for implementing dental care

Last name (also former, if any)	First name
Personal identity code	Telephone
Address	Domicile

	Yes	No
Do you currently have symptoms affecting your teeth or mouth?	☐	☐
Which symptoms do you have? _____		
In your opinion, are you in good health?	☐	☐
Have you been in continuous medical or hospital care?	☐	☐
Have you received radiation therapy in the head or neck area?	☐	☐
Have you experienced problems with local anesthesia?	☐	☐

	Yes	No
Are you pregnant? Due date: _____	☐	☐
Do you smoke or use snus?	☐	☐
How many cigarettes do you smoke in a day? _____		
Do you use ☐ alcohol ☐ drugs		
☐ daily ☐ 1-3 times a week ☐ 1-3 times a month		
☐ rarely ☐ never		

Please tick the box if you have or have had any of the following conditions or symptoms

☐ cardiovascular disease	☐ thyroid disorder	☐ kidney disease	☐ liver disease
☐ pacemaker, artificial heart valve	☐ rheumatism, rheumatic fever	☐ high blood pressure	☐ artificial joint
☐ hepatitis B ☐ hepatitis C	☐ blood disease, anemia	☐ tendency to bleed	☐ peptic ulcer
☐ HIV infection (AIDS)	☐ epilepsy	☐ diabetes	☐ recurring headache
☐ mental illness	☐ lung disease, asthma	☐ cancer	_____

☐ some other long-term disease, which:

Are you sensitive or allergic to medicines or other substances (e.g. sulfa, penicillin, rubber, food products) ☐ yes ☐ no

Which?

Do you have regular medication? ☐ yes ☐ no

Which?

Brushing of teeth: ☐ Less frequently than once a day ☐ once a day ☐ twice a day ☐ more frequently than twice a day

Toothbrush: ☐ standard ☐ electric Use of toothpaste that contains fluoride: ☐ yes ☐ no ☐ I don't know

Cleaning between the teeth: ☐ Yes, with which tool?_____ ☐ no

How often do you clean between the teeth? ☐ daily ☐ weekly ☐ less frequently Use of xylitol: ☐ yes ☐ no

Eating: ☐ max. 6 times a day ☐ more than 6 times a day Use of sweeteners in coffee/tea ☐ yes ☐ no

The use of sugary and acidic drinks: ☐ Several times a day ☐ daily ☐ weekly ☐ rarely

Other matters to observe in dental care:

Other additional information:

Date:	Signature: