Kymenlaakson hyvinvointialue
Kymmenedalens välfärdsområde

_____/_____20 _____

Oral health care 2023

PRELIMINARY INFORMATION FORM FOR ADULTS AND PEOPLE OVER 15 YEARS OVER IN DENTAL CARE
Dear client! Fill in this form when you arrive at the urgent dental care or if over 6 months have elapsed since your previous visit to the health centre's dental care.

Name:	Social security number:
Address:	Municipality of residence:
Telephone (during day):	Mobile phone:
Occupation:	Workplace:

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING DISEASES OR SYMPTOMS, OR HAD ANY OF THE PROCEDURES LISTED BELOW? (Please tick the relevant boxes)

___increased risk of bleeding
___hypertension, result from the latest measurement:___/ _____
___heart condition, please specify: _____
___artificial heart valve since: _____
___pacemaker since: _____
___blood vessel prosthesis since: _____
___artificial joint(s) since: _____
___radiation treatment in the head or neck area, year: _____
___diabetes
___rheumatic disease
___liver disease, please specify: _____
___kidney disease
___HIV/AIDS
___lung disease, asthma
___mental illness, nervous disorder
___epilepsy
___other general diseases, please specify: _____

___I have not been diagnosed with any general diseases or symptoms mentioned below, not have I had any of the procedures listed

___smoking
___snuff use

PREGNANCY
_____I am pregnant, due date:_____

ALLERGIES TO MEDICINES OR OTHER SUBSTANCES

___allergy to a medicine, please specify: _____
___other allergies, please specify: _____

ANAESTHESIA

___Have you been under anaesthesia before YES NO
___Were there any difficulties with the anaesthesia YES NO
if YES, what? _____

CONTINUOUS MEDICATION

____osteoporosis medication since:
___Marevan or some other anticoagulant, please specify:_____most recent INR level __
____omega-3 supplements
___pain-relieving medication: _____
___anti-hypertensive medication: _____
___anti-arrhythmic or other cardiac medication: _____
___cholesterol medication: _____
___antidepressants: _____
___antirheumatics: _____
___anti-asthmatic or allergy medication: _____
___cortisone medication: _____
___cytostatics: _____
___other regular medication, please specify: _____

CONSENT TO THE DISCLOSURE OF DENTAL DATA IF NECESSARY

___I give permission to disclose my information when the treating health centre changes

SIGNATURE_____/_____**20** _____ _____
Date signature