Health History & Informed Consent

Karlstad & Roseau Dental Clinics

[illegible] DDS
[illegible] DDS
[illegible] DDS
[illegible] DDS

[illegible], Karlstad, MN [illegible] | [illegible], Roseau, MN [illegible]

Name____________________________ Birthdate__________________ Date______________

Please check yes or no and answer the questions. The dentist or staff member will discuss any relevant health issues with you prior to treatment. This information is vital to providing you with safe and appropriate dental care.

Health Conditions

yes	no	
___	___	Artificial Heart Valves
___	___	Damaged Heart Valves
___	___	Heart murmurs
___	___	Heart Attack, if yes, when__________
___	___	Angina
___	___	High Blood Pressure
___	___	Low Blood Pressure
___	___	Stroke, if yes, when__________
___	___	Pacemaker
___	___	Arrhythmia
___	___	Congestive Heart Failure
___	___	Heart Transplant
___	___	Abnormal/Prolonged Bleeding
___	___	Anemia
___	___	Artificial Joints (hip, knee, elbow, finger)
___	___	Osteoporosis
___	___	Diabetes, insulin dependent (Type I)
___	___	Diabetes, non-insulin dependent (Type II)
___	___	AIDS or HIV infection
___	___	Hepatitis, specify type: A B C D
___	___	Tuberculosis
___	___	Sexually Transmitted Disease
___	___	Asthma
___	___	COPD
___	___	Emphysema
___	___	Cigarette Smoking
___	___	Use of chewing tobacco
___	___	Kidney Disease
___	___	Mental Illness
___	___	Epilepsy
___	___	Chronic Sinusitis

Women only Are you...

___	___	pregnant? If so, how many weeks?________
___	___	on birth control or hormonal replacement?
___	___	nursing ?

Allergies

yes	no	
___	___	Penicillin or other Antibiotics
___	___	Latex
___	___	Local Anesthetics (lidocaine)
___	___	Valium (diazepam)
___	___	Naxen (naproxen)
___	___	Tylenol (acetaminophen)
___	___	Ibuprofen
___	___	Codeine or other Narcotics
___	___	Aspirin
___	___	Metals (specify)____________

List allergies you have to medications, substances or materials not mentioned above:

________________ ________________

________________ ________________

Medications

yes	no	
___	___	Coumadin (warfarin)
___	___	Fosamax, Boniva (bisphosphonate)

If yes for Fosamax, etc., in what month/year did you begin taking it? ________________

List any additional prescription and non-prescription medications you are currently taking.

________________ ________________

________________ ________________

________________ ________________

________________ ________________

I certify that I have responded truthfully about my health and acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold the dentist and his/her staff responsible for an action they take or do not take because of errors or omissions that I may have made in the completion of this form. I give my consent to Dr. [illegible], Dr. [illegible], Dr. [illegible] and Dr. [illegible] to perform examinations, restorative dental care, nitrous oxide sedation and local anesthesia (lidocaine) and for them and the hygienists working under their supervision to perform dental scaling, periodontal root planing, dental prophylaxis, photographs, insertion of pre-adjusted orthodontic appliances, impressions, x-rays and the application of fluoride & medicaments and for the dental assistants working under their supervision to perform the same services as the hygienists with the exception of dental scaling and periodontal root planing on me or my child.

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Signature of patient, parent or legal guardian Date