Saskatchewan Health Authority

Resident Label

NAME: _____

HSN: _____

D.O.B.: _____

LONG TERM CARE
ORAL HEALTH PROGRAM
HOME: _____

MEDICAL HISTORY FORM FOR DENTAL EXAMINATION/TREATMENT

Personal Health Information

Resident's name: _____

Room #: _____ Unit telephone #: _____

Date of birth: _____ ❑ Male ❑ Female

Dental benefits/Insurance: _____

Saskatchewan Personal Health (health card #): _____

Veteran Affairs (K #): _____

First Canadian Health (Treaty #): _____

Person responsible for account: _____

Billing address: _____

Email address for family representative: _____

Phone number for family representative: _____

Medical History

1. Name of physician: _____
   Physician phone #: _____ Physician fax #: _____
2. Have you been hospitalized: ❑ Yes ❑ No
   If yes, please explain: _____
3. Current Medication Administration Review (MAR) list attached: ❑ Yes ❑ No
4. Are you allergic to latex: ❑ Yes ❑ No
5. Do you have any allergies: ❑ Yes ❑ No
6. Have you ever had an allergic reaction to any drug or anesthetic, at the time or later: _____
   _____
   _____
7. Do you bruise easily or have prolonged bleeding: ❑ Yes ❑ No
8. Have you ever fainted, had shortness of breather, or had chest pains: ❑ Yes ❑ No
9. Do you have a heart or circulatory problem of any kind: ❑ Yes ❑ No
10. Are you taking or have you taken bisphosphonate drugs such as Fosamax®, Skelid®, or Actonel® (for osteoporosis) or Aredia®, Zometa®, or Didronel® (for cancer treatments): ❑ Yes ❑ No
11. If you checked yes for #10, how were the drugs given: ❑ Oral ❑ I.V. Duration of therapy: _____
12. Are you MRSA, ESBL, or VRE positive (+): ❑ Yes ❑ No If yes, which one? _____

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13. Do you have/had any of the following:

- ❑ Aids
- ❑ Anemia
- ❑ Angina
- ❑ Anorexia
- ❑ Antibiotic resistance organisms
- ❑ Arthritis
- ❑ Artificial heart valve
- ❑ Artificial joints
- ❑ Asthma
- ❑ Blood disorder
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Diabetes
- ❑ Drug dependence
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Head/neck injury
- ❑ Heart disease
- ❑ Heart murmur
- ❑ Heart pacemaker
- ❑ Heart rhythm disorder
- ❑ Hepatitis A/B/C
- ❑ Herpes
- ❑ High/Low blood pressure
- ❑ HIV
- ❑ Implanted electrical devices
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Leukemia
- ❑ Lung disease
- ❑ Mental disorder
- ❑ Mitral valve prolapse
- ❑ Organ transplant
- ❑ Radiation/chemo
- ❑ Rheumatic/Scarlet fever
- ❑ Sinus trouble
- ❑ Stomach problems
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Sexually Transmitted Infection

14. Have you ever had any illness not included above: ❑ Yes ❑ No

If yes, explain: _____

Consent for Dental Examination/Treatment

I understand the information contained in the medical and dental history is important to my dental examination and treatment. I certify all the information I have completed is correct, and I have not knowingly omitted information.

I authorize the dentist/oral health professional to perform diagnostic procedures, including x-rays and photographs inside and outside the mouth. Any photographs taken of the resident and/or family member may be used for education purposes. This also includes collecting personal health information as required to determine necessary treatment. This includes consultation with other health professionals as necessary.

A prescription for mild oral sedation may be required prior to dental treatment. If necessary, I consent to the physician providing a sedation prescription.

The collection of health and dental information is consistent with the requirements of our profession and those of the *Health Information Protection Act of Saskatchewan* and the *Personal Information Protection and Electronic Documents Act of Canada*. I understand that if I have provided an email address that correspondence may occur through email.

We acknowledge out duty and responsibility to hold in confidence your personal health information gathered in the course of our professional relationship.

I understand it is my responsibility to pay for dental treatment.

_____ _____

Signature Date

_____

Name (print)