|  |  |
| --- | --- |
| **Patient Name:** | **Date:**  **MM/DD/YYY** |
| **Medical Health History**  |
|  |
| 1. Are you currently under the care of a physician? ……………………………………………….….
 | [ ]  Yes | [ ]  No |
|  | If yes, what for? |       |
|  |
| 1. Have you ever had any serious illness or been hospitalized? ……………………………............
 | [ ]  Yes | [ ]  No |
|  | If yes, what for? |       |
|  |
|  |
| 1. Please place an “X” into the appropriate box for the listed health issues. Indicate yes if you have had the condition even if you do not currently have that condition.
 |
| **YES** | **NO** |  | **YES** | **NO** |  |
| **[ ]**  | [ ]  | Alcohol problems:      | [ ]  | [ ]  | HIV / AIDS:      |
| **[ ]**  | [ ]  | Drug Dependency- Specify:      | [ ]  | [ ]  | Sexual Transmitted disease:      |
| **[ ]**  | [ ]  | Environmental Allergies. Specify:      | [ ]  | [ ]  | Immune Deficiency:      |
| **[ ]**  | [ ]  | Food Allergies. Specify:      | [ ]  | [ ]  | Herpes Virus (cold sores) :      |
| **[ ]**  | [ ]  | Latex Allergy:       |  |  |  |
| **[ ]**  | [ ]  | Other Allergies. Specify:      | [ ]  | [ ]  | Kidney Disease:      |
|  |  |  | [ ]  | [ ]  | Kidney Stones:      |
| **[ ]**  | [ ]  | Asthma:      |  |  |  |
| **[ ]**  | [ ]  | Chronic Obstructive Pulmonary Disease:      | [ ]  | [ ]  | Heart Attack:      |
| **[ ]**  | [ ]  | Difficulty breathing:      | [ ]  | [ ]  | Heart Disease:      |
| **[ ]**  | [ ]  | Emphysema:      | [ ]  | [ ]  | Rheumatic Fever:      |
| **[ ]**  | [ ]  | Tuberculosis:      | [ ]  | [ ]  | Heart Murmur:      |
|  |  |  | [ ]  | [ ]  | Heart Surgery:      |
| **[ ]**  | [ ]  | Hepatitis A:      |  | [ ]  | [ ]  | Artificial Heart Valve:      |
| **[ ]**  | [ ]  | Hepatitis B:      | [ ]  | [ ]  | Pacemaker:      |
| **[ ]**  | [ ]  | Hepatitis C:      | [ ]  | [ ]  | Angina pectoris:      |
| **[ ]**  | [ ]  | Other Liver Disease: Specify:       |  |  |  |
|  |  |  | [ ]  | [ ]  | Cholesterol problems:      |
| **[ ]**  | [ ]  | Arthritis:      | [ ]  | [ ]  | High Blood Pressure:      |
| **[ ]**  | [ ]  | Artificial Joint replacement- Specify:      | [ ]  | [ ]  | Low Blood Pressure:      |
|  |  |       | [ ]  | [ ]  | Bleeding Disorder/Haemophilia:       |
|  |  |  | [ ]  | [ ]  | Stroke:      |
| **[ ]**  | [ ]  | Cancer. Specify:      |  |  |  |
| **[ ]**  | [ ]  | Chemotherapy/Radiation therapy:      | [ ]  | [ ]  | Nervousness/Psychiatric condition:      |
|  |  |  |  |  |  |
| **[ ]**  | [ ]  | Diabetes Type 1:      | [ ]  | [ ]  | Organ Transplant : If yes, specify:       |
| **[ ]**  | [ ]  | Diabetes Type 2:      |  |  |       |
| **[ ]**  | [ ]  | Eating disorder. If yes: [ ] anorexia [ ] bulimia | [ ]  | [ ]  | Thyroid Disease. If yes: [ ]  Hyper [ ] Hypo |
|  |  |  |  |  |  |
| **[ ]**  | [ ]  | Epilepsy or Seizures:      | [ ]  | [ ]  | Surgeries- specify:       |
| **[ ]**  | [ ]  | Dizziness/fainting:      |  |  |        |
|  | **[ ]**  | Other. Specify:       |
| Office Use Only:  |
|  |
|  |
|  |
|  |
|  |
| 1. Have you ever experienced a bad reaction to any of the following medications:
 |  |
| **Medication** | **Yes**  | **No** | **Never Used** | **Medication** | **Yes** | **No** | **Never Used** |
| Anaesthetic | [ ]  | [ ]  | [ ]  | Penicillin | [ ]  | [ ]  | [ ]  |
| Barbiturates (sleeping pills) | [ ]  | [ ]  | [ ]  | Sulphonamides (sulpha) | [ ]  | [ ]  | [ ]  |
| Codeine | [ ]  | [ ]  | [ ]  | Tranquilizers | [ ]  | [ ]  | [ ]  |
| Cortisone (steroids) | [ ]  | [ ]  | [ ]  |  |  |  |  |
| Other- please list:  | [ ]  |       |
| 1. Are you taking any medications, over the counter medications or herbal remedies? …………..
 | [ ]  Yes | [ ]  No |
|  | If yes, what? |       |
|  |  |       |
|  | If yes, what for? |       |
|  |  |       |
|  |
| 1. Are you allergic to any foods, metals or latex? …………..………………………..….
 | [ ]  Yes | [ ]  No |
|  | If yes, please list: |       |

|  |
| --- |
|  |
| 1. Have you recently lost or gained a significant amount of weight? ………………………………..
 | [ ]  Yes | [ ]  No |
| If yes, how much? ……………………………………..…………….......... | Gained:      kg/lbs | Lost:      kg/lbs |
|  |
| 1. Do you smoke or use chewing tobacco? …………………………………………………………….
 | [ ]  Yes | [ ]  No |
| If yes, which and for how long? |       |
|  |
| 1. Do you frequently have indigestion? …………………………………………………………………
 | [ ]  Yes | [ ]  No |
|  |
| 1. If yes to question #10, do you take anything for the indigestion? …………………………………
 | [ ]  Yes | [ ]  No |
|  | If yes, what do you take? |       |
|  |
| 1. Are you pregnant? ……………………………………………………………………………………….
 | [ ]  Yes | [ ]  No |
|  | [ ]  NA : Male |
|  |
| 1. Do you have any other health issues which have not been addressed above?………….………...
 | [ ]  Yes | [ ]  No |
|  | If yes, please list: |       |
|  |  |       |
|  |  |       |
|  |  |  |

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| --- |
| **Office Use Only****Additional Notes related to Responses on the Medical History** |
| QuestionNumber | Notes |
|  |  |
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| **Patient Name:**  | **Date:** **MM/DD/YYY** |
| **Dental Health History Please place an “X” into the appropriate box or provide your written response** |
|  |
| 1. When was your last dental visit? ………………………………..…….
 |  |
|  |
| 1. What procedures did you have done at that visit? ……………….…
 |       |
|  |
| 1. Have you had any complications following a dental procedure? ................................................
 | [ ]  Yes | [ ]  No |
| If yes, please explain |       |
|  |
| 1. Have you had dental x-rays done in the last two (2) years? …………..……………………….......
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you have any dental work ongoing at this time? ……………………………..………..………...
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you have any outstanding dental work to be done? …………………………………..………...
 | [ ]  Yes | [ ]  No |
| If yes, what procedures  |       |
| need to be done? |       |
|  |
| 1. Have you had any complications following a dental procedure? ……………………………….....
 | [ ]  Yes | [ ]  No |
| If yes, please specify: |       |
|  |
| 1. Do you have any sensitive teeth (if applicable)? …………………………………………………….
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do your gums bleed (if applicable)? ……………………………………………………………….....
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you normally have a bad taste in your mouth?..…………………………………………………
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you normally have an unpleasant odour/taste in your mouth? ………………………………...
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you have any pain in your jaw joint? ……………………………………………………..............
 | [ ]  Yes | [ ]  No |
|  |  |  |
| 1. Do you clench or grind your teeth? .............................................................................................
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you have dental implants? ………………………………………...............................................
 | [ ]  Yes | [ ]  No |
|  |
| 1. Have you ever had an accident or had trauma/injury to your neck or jaws? ...............................
 | [ ]  Yes | [ ]  No |
|  | If yes, specify: |       |
|  |
| 1. Do you have any pain or numbness in your head, neck or jaws? …….…………………………...
 | [ ]  Yes | [ ]  No |
|  | If yes, specify: |       |
|  |
| 1. Do you have any sore spots or anomalies in your mouth? .……………………………................
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you have any habits which affect your mouth such as mouth breathing, chewing objects, chewing nails, etc? ……………………………………………………………………………………...
 | [ ]  Yes | [ ]  No |
|  | If yes, specify: |       |
|  |
| 1. Have you been diagnosed with Sleep Apnea? ………………..……….……………………….....
 | [ ]  Yes | [ ]  No |
|  | If yes, by who? |       | Phone: |       |
|  |
| 1. Do you have any other dental health issues which have not been addressed above? …………
 | [ ]  Yes | [ ]  No |
| If yes, please specify: |       |
|  |
| **Complete the following questions only if you have some or all of your natural teeth** |
|  |
| 1. How often do you brush your teeth?
 | [ ]  Daily | [ ]  Weekly | [ ]  Other (specify)  |       |
|  |
| 1. How often do you floss your teeth?
 | [ ]  Daily | [ ]  Weekly | [ ]  Other (specify)  |       |
|  |
| 1. How often do you see a Hygienist?
 | [ ]  Yearly | [ ]  Bi-Yearly | [ ]  Other (specify)  |       |

|  |
| --- |
| **Complete the following questions only if you have a denture or dentures** |
| 1. What type of dentures do you have? (complete or partial)
 | Complete: | Upper: [ ]  | Lower: [ ]  |
|  | Partial: | Upper: [ ]  | Lower: [ ]  |
|  |
| 1. When were your dentures made?..…….…………….............
 | Upper:       (year) | Lower:       (year) |
|  |
| 1. Who provided you with the dentures? ……..………………….
 | Upper: |       |
|  [ ]  Unknown/Prefer not to say | Lower: |       |
|  |
| 1. Do your gums get sores under your denture(s)? …………...
 | Upper [ ]  Yes [ ]  No | Lower [ ]  Yes [ ]  No |
|  | If yes, how often | [ ]  Daily | [ ]  Weekly | [ ]  Occasionally | [ ]  Other (Specify): |       |
|  |
| 1. Do you brush your gums under your denture(s)? …….....…..
 | Upper [ ]  Yes [ ]  No | Lower [ ]  Yes [ ]  No |
|  |
| 1. Do you wear your denture(s) at night (if applicable)? …...…..
 | Upper [ ]  Yes [ ]  No | Lower [ ]  Yes [ ]  No |
|  |
| 1. How many dentures have you had (if applicable)? …............
 | Upper:        | Lower:       |
|  |
| 1. Are you happy with the appearance of your dentures? ……………………………………………..
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you have problems eating any particular types of food? ……………………………………..
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you use denture adhesives? ……………………………………………………………………….
 | [ ]  Yes | [ ]  No |
|  |
| 1. Have the benefits of dental implants been discussed with you? ………………………………...
 | [ ]  Yes | [ ]  No |
|  |

***“I the undersigned, hereby certify that all of the medical and dental information provided on this form to be true to the best of my knowledge and that I have not knowingly omitted any information. I also consent to my family physician/family dentist being contacted, if necessary, to obtain further information or clarification of medical/dental conditions as is necessary for my denturist treatment****.”*

*Dated this \_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_, 20\_\_\_.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature

|  |
| --- |
| **Office Use Only****Notes related to Responses on the Dental History** |
| QuestionNumber | Notes |
|  |  |
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|  |  |
|  |  |
|  |  |
|  |  |
| **The Medical and Dental History has been reviewed by myself and discussed with the patient:** |
| Practitioner Signature: |  |