|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: |  | | | | | | | | |
|  |  |  | | | | | | | | |
|  |  |  | | | | | | | | |
|  | | | | | |  | | |  | |

|  |  |
| --- | --- |
| **Office Use Only**  **Additional Notes related to Responses on the Medical History** | |
| Question  Number | Notes |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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*      *\_\_\_\_\_\_\_\_\_\_, 2019.*

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

Patient Signature

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