Patient Medical Info/History

Full Name ______________________________ **Date**______________.

Health Card Number:…………………. **Date of Birth:**……………………. **Email:**…………………………………………….

Address:………………………………………………………………………... **Referred By:**………………………………..

Tel Contact Home:…………………….. **Mobile:**…………………………… **Work:**…………………………………………

Emergency Contact:………………………………………. **Emergency Contact Number:**………………………………..

Physician ______________________________. **Office Phone**______________ **Date of Last Exam** ______________.

Are you under a physician's care now? ☐ Yes ☐ No **If yes, please explain:**______________________________.

Have you recently been hospitalized? ☐ Yes ☐ No **If yes, please explain:**______________________________.

Are you taking any medications, pills, or herbal remedies? ☐ Yes ☐ No

Please list drugs: ______________________________.

______________________________.

______________________________.

______________________________.

Are you on a special diet? ☐ Yes ☐ No ……………………………......

Do you smoke or use chewing tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No ………………………...

Have you recently lost or gained a significant amount of weight? ☐ Yes ☐ No

If yes, how much? ………………………………… **Gained:**__________. **Ibs** **Lost: :**__________. **Ibs**

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Local Anesthetics ☐Acrylic ☐Metal ☐Latex ☐Sulfa Drugs

☐Other **If yes, please explain:** ____.

Do you have, or have you had, any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease/Dementia
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Breathing Problem/COPD
- ☐ Cancer
- ☐ Chest Pain
- ☐ Cold Sores
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Digestive Disorders/ Acid Reflux
- ☐ Drug/ Alcohol Dependency
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Headaches
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head/Neck Injury
- ☐ Heart Attack
- ☐ Hearing Loss
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ High/Low Blood Pressure
- ☐ High Cholesterol
- ☐ Hodgkinds Disease
- ☐ Hypo/Hyperglycemia
- ☐ Kidney Disease
- ☐ Lung disease
- ☐ Lupus
- ☐ Migraine
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Parkinsons Disease
- ☐ Psychiatric Care (e.g. BD, BPD)
- ☐ Radiation/Chemotherapy
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ TMJ Disorder
- ☐ Tuberculosis
- ☐ Ulcerative Colitis/Crohn's Disease

Are there any conditions or diseases not listed above that you have or have had?______________________________.

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer, or heart disease) ☐Yes ☐No

If yes, please explain……………………………………… **Patient Signature** ______________________________.

Patient Dental Info/History

Full Name ______________________________ **Date** ______________.

Name of Previous Dentist: ______________________________ **Prev. Dentist's location** ______________________________.

When was your last dental visit?....................................... **When did you last have dental x-rays taken?**...............................

What procedures were done, if any?..

Do you have any outstanding dental work to be done? ☐Yes ☐No **If yes, please explain** ....

....

Have you been seeing a Dentist regularly? ☐Yes ☐No

How often do you brush your teeth? ☐N/A ☐Never ☐Rarely ☐Sometimes ☐Daily ☐>1/day

Do your gums bleed when you brush? ☐Yes ☐No

Are your teeth sensitive to hot or cold liquids/foods? ☐N/A ☐Yes ☐No

Do you feel pain in any of your teeth? ☐N/A ☐Yes ☐No **If yes, please explain**..

Do you have an unpleasant odour/taste in your mouth? ☐Yes ☐No

Do you have any sores or lumps in or near your mouth? ☐Yes ☐No

Have you had any head, neck, or jaw injuries? ☐Yes ☐No **If yes, please explain**..

Do you clench or grind your teeth? ☐Yes ☐No

Do you bite your lips or cheeks frequently? ☐Yes ☐No

Do you like your smile? ☐Yes ☐No

Have you ever had any implant surgery? ☐Yes ☐No **If yes, please explain**..

Have the benefits of dental implants been discussed with you? ☐Yes ☐No

Are you being followed up by a dental specialist? ☐Yes ☐No **If yes, by whom?**..

Have you ever had any prolonged bleeding following extractions? ☐N/A ☐Yes ☐No

Have you ever experienced any of the following problems in your jaw? ☐Yes ☐No

☐ **Clicking, popping** ☐ **Pain (joint, ear, side of face)** ☐ **Difficulty in opening or closing** ☐ **Difficulty in chewing**

DENTURE HISTORY

What type of dentures do you have? **COMPLETE:** ☐Upper ☐Lower **OR** **PARTIAL:** ☐Upper ☐Lower

If you wear a partial denture, excluding clasps, is the base ACRYLIC / METAL / FLEXIBLE ACRYLIC? (circle one)

When were your dentures made approximately? Upper: ____________ **(mm/yyyy) Lower:** ____________ **(mm/yyyy)**

Who provided you with the dentures?... ☐Unknown/Prefer not to say

Is there anything about the appearance of your dentures you would like to change? ☐Yes ☐No

☐ **Tooth Color** ☐ **Tooth Shape** ☐ **Bite Position** ☐ **Other, please explain:** ______________________________.

Do you get sores under your dentures? ☐Yes ☐No **If yes, how often?** ☐Daily ☐Weekly ☐Occasionally ....

Do you use Denture adhesives? ☐Yes ☐No **Do you wear your dentures at night?** ☐Yes ☐No

The information I have given above is true to the best of my knowledge. PHIA permits us to collect and use your personal Health information. In certain circumstances, PHIA also allows us to share it with others both inside and outside our organization to: provide you with health care, get payment for your care which could include private insurers, do health system planning and research, and report as required by law.

Patient Signature ______________________.