Patient Name: **Patient Name:** **Date:**
MM/DD/YYY

Medical Health History

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 or Drug Dependency:	☐	☐	HIV / AIDS:
☐	☐	Allergies. Specify:	☐	☐	Kidney Disease:
☐	☐	Difficulty breathing: COPD/ Asthma	☐	☐	Heart Disease: Specify:
☐	☐	Hepatitis A B C: Specify:	☐	☐	Angina pectoris:
☐	☐	Other Liver Disease: Specify:			
☐	☐	Arthritis:	☐	☐	Blood Pressure problems:
			☐	☐	Stroke:
☐	☐	Cancer. Specify:			
☐	☐	Chemotherapy/Radiation therapy:	☐	☐	Diabetes 1 or 2:

1. Are you taking any medications, over the counter medications or herbal remedies? …….. ☐ Yes ☐ No
   If yes, what for?
2. Have you recently lost or gained weight If yes, how much? …….. ☐ Yes ☐ No
3. Do you smoke or use chewing tobacco? ……. ☐ Yes ☐ No
   If yes, for how long?
4. Do you frequently have indigestion? If yes, what do you take? ……..... ☐ Yes ☐ No
5. Are you pregnant? ……. ☐ Yes ☐ No
6. Do you have any other physical or mental health issues which have not been addressed above?……..... ☐ Yes ☐ No
   If yes, please list:

Dental Health History

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: ☐
2. When were your dentures made?..……..... Upper: _____ (year) Lower: _____ (year)
3. Do your gums get sores under your denture(s)? ……... Upper ☐ Yes ☐ No Lower ☐ Yes ☐ No
   If yes, how often ☐ Daily ☐ Weekly ☐ Occasionally ☐ Other (Specify):
4. Do you brush your gums under your denture(s)? ……..….. Upper ☐ Yes ☐ No Lower ☐ Yes ☐ No
5. Do you wear your denture(s) at night? ….…….. Upper ☐ Yes ☐ No Lower ☐ Yes ☐ No
6. How many dentures have you had? …..... Upper: _____ Lower: _____
7. Are you happy with the appearance of your dentures? ☐ Yes ☐ No
8. Do you have problems eating any particular types of food? …….. ☐ Yes ☐ No
9. Do you use denture adhesives? ☐ Yes ☐ No
10. Have the benefits of dental implants been discussed with you? …….. ☐ Yes ☐ No

Complete the following questions only if you have all or some of your natural teeth

1. When was your last dental visit? ……..…….

2. Have you had any complications following a dental procedure? ..... ☐ Yes ☐ No
   If yes, please explain

3. Do you have any dental work ongoing at this time? ……..……..……... ☐ Yes ☐ No

4. Do you have any sensitive teeth (if applicable)? ……. ☐ Yes ☐ No

5. Do your gums bleed (if applicable)? ……..... ☐ Yes ☐ No

6. Do you normally have a bad taste in your mouth?..…… ☐ Yes ☐ No

7. Do you have any pain in your jaw joint? ……..... ☐ Yes ☐ No

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

9. Do you have dental implants? ……..... ☐ Yes ☐ No

10. Have you ever had an accident or had trauma/injury to your neck or jaws? ..... ☐ Yes ☐ No
    If yes, specify:

11. Do you have any pain or numbness in your head, neck or jaws? ……... ☐ Yes ☐ No
    If yes, specify:

12. Do you have any sore spots or anomalies in your mouth? ……..... ☐ Yes ☐ No

13. Do you have any habits which affect your mouth such as mouth breathing, chewing objects, chewing nails, etc? ……... ☐ Yes ☐ No
    If yes, specify:

14. Have you been diagnosed with Sleep Apnea? ……..……..... ☐ Yes ☐ No

15. Do you have any other dental health issues which have not been addressed above? …… ☐ Yes ☐ No
    If yes, please specify:

16. How often do you brush your teeth? ☐ Daily ☐ Weekly ☐ Other (specify)

17. How often do you floss your teeth? ☐ Daily ☐ Weekly ☐ Other (specify)

18. How often do you see a Hygienist? ☐ Yearly ☐ Bi-Yearly ☐ Other (specify)

"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