

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

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 <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| | | | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

PRELIMINARY QUESTIONNAIRE (FOR THOSE WHO HAVE FULL DENTURES):

My lower teeth were extracted about ____ years ago and my upper teeth about ____ years ago.

My last upper denture was fitted in my mouth about ____ years ago and the lower denture ____ years ago.

I heard about you clinic from: _____

Given that the stability of natural teeth is perfect and equal to 10/10, how would you approximately rate the stability of your upper denture? ____/10 And your lower denture? ____/10

What degree of stability are you hoping to obtain with your next upper denture? ____/10

What degree of stability are you hoping to obtain with your next lower denture? ____/10

Please indicate which of the following problems concern you (please check yes, no, or occasionally)
Also, please circle the numbers of the 3 problems that bother you the most.

	YES	NO	OCCASIONAL
1. Frequent gum pain, or gum ulcers on the top or bottom gums.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Occasional tingling or "electric shocks" of the lip when chewing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Difficulty eating raw vegetables (carrots, celery), nuts or corn-on-the-cob..... (If I do eat them, the next day I will be uncomfortable and have ulcers or some pain.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The fact that my upper and lower jaw bones are shrinking each year is worrying me...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Food gets under my <input type="checkbox"/> lower <input type="checkbox"/> upper denture.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. My teeth don't cut anymore.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I have digestive problems (hyperacidity, stomach ulcers, constipation, chronic diarrhea, irritable bowel syndrome.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Cracking or pain of the jaw joints.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Earaches or headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I sleep with my dentures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I have a tendency to bite down on my teeth.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I have dry mouth.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I have too much saliva.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I am satisfied with how my teeth look right now.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. My teeth don't show enough.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. My lips are sunken and becoming more wrinkled.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I'm afraid of losing my denture in public.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. My <input type="checkbox"/> lower <input type="checkbox"/> upper denture is loose.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you recently consulted for new prostheses? YES NO

Would you like us to take the time necessary to clearly explain to you the solution (s) to your problems before deciding on your choice of treatment? YES NO

Last name: _____ First name: _____

Today's date: ____/____/____

Signature: _____