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

Concept Dental

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.....	☐	☐	☐
2. Occasional tingling or "electric shocks" of the lip when chewing.....	☐	☐	☐
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.)	☐	☐	☐
4. The fact that my upper and lower jaw bones are shrinking each year is worrying me...	☐	☐	☐
5. Food gets under my ☐ lower ☐ upper denture.....	☐	☐	☐
6. My teeth don't cut anymore.....	☐	☐	☐
7. I have digestive problems ..... (hyperacidity, stomach ulcers, constipation, chronic diarrhea, irritable bowel syndrome.)	☐	☐	☐
8. Cracking or pain of the jaw joints.....	☐	☐	☐
9. Earaches or headaches.....	☐	☐	☐
10. I sleep with my dentures.....	☐	☐	☐
11. I have a tendency to bite down on my teeth.....	☐	☐	☐
12. I have dry mouth.....	☐	☐	☐
13. I have too much saliva.....	☐	☐	☐
14. I am satisfied with how my teeth look right now.....	☐	☐	☐
15. My teeth don't show enough.....	☐	☐	☐
16. My lips are sunken and becoming more wrinkled.....	☐	☐	☐
17. I'm afraid of losing my denture in public.....	☐	☐	☐
18. My ☐ lower ☐ upper denture is loose.....	☐	☐	☐

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: _____