PROSTHODONTIC ASSOCIATES

Medical History Form

Title:_____ First Name: _____Last Name: _____Preferred Name:_____

Address: _____City:_____Province:_____Postal Code:_____

Home #:_____ Cellular #:_____ Work #:_____Email:_____

Contact Method:_____Occupation:_____Employer/School:_____

Emergency Contact:_____Telephone #:_____ Emergency Relationship:_____

Date of Birth: year_____month_____day_____Gender:_____Are you available for Short Notice Appointments?:_____

If you were referred to this office, by whom were you referred:_____

MEDICAL INFORMATION:

Dental professionals primarily treat the area in and around your mouth. Since your mouth is part of your body any medications you are taking as well as your medical history have an important relationship with your Dental Treatment. Please answer the following questions.

Are you seeing a Family Physician? If so, please enter name, phone number and date of last visit. ❒Yes ❒No

_____

Have you recently (in the last two years) been hospitalized or had a major operation? Please explain. ❒Yes ❒No

_____

Have you ever had a serious head or neck injury? If so, please explain. ❒Yes ❒No

_____

For Women Only: Taking Birth control pills? ❒Yes ❒No Are you or could you be pregnant? ❒Yes ❒No

If yes, what is the expected delivery date? _____

Please go over the following section and indicate which of the following you have or have had. If you need to add any further information, please enter it at the end.

AIDS/HIV Positive	❒Yes ❒No	Chest Pains	❒Yes ❒No	Hemophilia	❒Yes ❒No
Alzheimer's Disease	❒Yes ❒No	Circulation Problems	❒Yes ❒No	Hepatitis A	❒Yes ❒No
Anaphylaxis	❒Yes ❒No	Diabetes	❒Yes ❒No	Hepatitis B or C	❒Yes ❒No
Anemia	❒Yes ❒No	Emphysema	❒Yes ❒No	High Blood Pressure	❒Yes ❒No
Arthritis/Gout	❒Yes ❒No	Epilepsy/Seizures	❒Yes ❒No	Kidney Problems	❒Yes ❒No
Artificial Heart Valve	❒Yes ❒No	Fainting	❒Yes ❒No	Liver Problems	❒Yes ❒No
Artificial Joint	❒Yes ❒No	Glaucoma	❒Yes ❒No	Lung Disease	❒Yes ❒No
Asthma	❒Yes ❒No	Head or Neck Injuries	❒Yes ❒No	Mental/Nervous Disorder	❒Yes ❒No
Blood Disease	❒Yes ❒No	Heart Attack/Failure	❒Yes ❒No	Organ/Medical Transplant	❒Yes ❒No
Bruise Easily	❒Yes ❒No	Heart Murmur	❒Yes ❒No	Sickle Cell Disease	❒Yes ❒No
Cancer	❒Yes ❒No	Heart Pace Maker	❒Yes ❒No	Stroke	❒Yes ❒No
Chemotherapy	❒Yes ❒No	Heart Surgery	❒Yes ❒No	Tuberculosis	❒Yes ❒No
Hypothyroidism	❒Yes ❒No	Hyperthyroidism	❒Yes ❒No	Endocrine Problems	❒Yes ❒No

Please enter details or any further information:_____

List all drugs/medications you are taking (if you are taking more than four medications, please attach a separate list):

1) Name_____ Dosage_____
   Frequency_____ Reason_____
2) Name_____ Dosage_____
   Frequency_____ Reason_____
3) Name_____ Dosage_____
   Frequency_____ Reason_____
4) Name_____ Dosage_____
   Frequency_____ Reason_____

Are you allergic to or have you had a reaction to any of the following items?

Barbiturates, sedatives, or sleeping pills	❒Yes ❒No	Nitrous Oxide	❒Yes ❒No
Aspirin	❒Yes ❒No	Codeine	❒Yes ❒No
Darvon	❒Yes ❒No	Local Anesthetic	❒Yes ❒No
Antibiotics	❒Yes ❒No	Other:_____	

If yes, please indicate the name of the antibiotic:_____

If you have ever been advised against taking any type of medication, please list them:_____

If you have any allergic conditions please list them. This can include asthma, hay fever, food allergies, and metal or latex allergies.

_____

Have you ever had any joint replacement surgery? ❒Yes ❒No

If yes, please indicate type and date of the surgery_____

Have you been told by your MD that you need to take premedication (antibiotics) one hour before your dental appointment? ❒Yes ❒No

If yes, please indicate:

Name of antibiotic_____ Dosage_____Amount_____Reason for the prescription_____

Do you use any form of Tobacco?	❒Yes ❒No	Are wearing a nicotine patch?	❒Yes ❒No
If yes, number of cigarettes per day:_____			
Number of years:_____			
Are you dependent on Alcohol or drugs?	❒Yes ❒No	Do you bruise easily, or bleed severely when you are cut?	❒Yes ❒No
Do you have severe earaches, ear or throat infections or headaches?	❒Yes ❒No	Do you wear glasses or contact lenses?	❒Yes ❒No

DENTAL INFORMATION:

In the following sections, please select whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you may be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Do your gums bleed while brushing or flossing?	❒Yes ❒No	Do you bite your lip or cheeks frequently?	❒Yes ❒No
Have you ever had Orthodontic (braces) treatments?	❒Yes ❒No	Do you have Headaches or Migraines?	❒Yes ❒No
Are your teeth sensitive to cold, hot, sweets or pressure?	❒Yes ❒No	Have you had any difficult extractions?	❒Yes ❒No
Do you feel pain to any of your teeth?	❒Yes ❒No	Ever worn a bite plate or other appliances?	❒Yes ❒No
Do you have any sores or lumps in or near your mouth?	❒Yes ❒No	Have you ever had difficulty opening or	
Have you ever had a head, neck or jaw injury?	❒Yes ❒No	closing your jaw?	❒Yes ❒No
Do you have any loose teeth or have they ever shifted?	❒Yes ❒No	Have you had any pain in your jaw area?	❒Yes ❒No
Does food frequently get caught in your teeth?	❒Yes ❒No	Have you ever had Periodontal Treatment (gums)?	❒Yes❒No

Please enter details or any further information:_____

_____

_____

Please give a brief description of your Oral Hygiene Habits:_____

If you have a current dental problem, please describe:_____

Do you have any concerns about having Dental Treatment? If so, please explain._____

Are you happy with the appearance of your teeth? If no, please explain._____

Do you ever feel nervous about visiting a Dentist? If so, please explain._____

Please enter your Dentist name and location:_____

Date of your last X-Ray:_____Date of your last teeth cleaning:_____ Date of your Last Dental Exam:_____

What can we do to make you smile? Check all that apply, and we will get back to you with more information about your inquiry:

Veneers❒	Oral Conscious Sedation❒	Broken/Cracked Teeth❒	Dental Implants❒
Invisalign Teeth Straightening❒	Gummy Smile❒	Total Smile Makeovers❒	Replace Missing Teeth❒
One Hour In-House Whitening❒	Cosmetic Dentures❒	White Fillings❒	Replace Metal Fillings❒
Rejuvenate Worn/Stained Teeth❒	Eliminate Gaps❒	Sleep Apnea/Snoring❒	Correct Misaligned Teeth❒

FOR DENTURE WEARERS:

Do you have:
❒CUD – Complete Upper Denture
Present denture received:_____Age when you got your first CUD:_____Year_____
❒CLD – Complete Lower Denture
Present denture received:_____Age when you got your first CLD:_____Year_____
❒RPUD – Removable Partial Upper Denture
Present denture received:_____Age when you got your first RPUD:_____Year_____
Your present RPUD is made of:
❒Metal and plastic ❒Plastic/wire hooks
Replacing:
❒All back teeth ❒All front teeth ❒Some back teeth ❒Some front teeth
❒RPLD – Removable Partial Lower Denture
Present denture received:_____Age when you got your first RPLD:_____Year_____
Your present RPLD is made of:
❒Metal and plastic ❒Plastic/wire hooks
Replacing:
❒All back teeth ❒All front teeth ❒Some back teeth ❒Some front teeth

Do you need denture adhesives? ❒Yes ❒No
Would you like to anchor your denture to your jaw bone more securely? ❒Yes ❒No

If you were to change anything in the next denture, it would be:

❒Colour ❒Shape ❒Teeth size ❒Length

❒Width ❒Arrangement ❒Distance from chin to nose ❒Amount they show when you smile

I hereby certify the above information is true and accurate. I acknowledge that in an effort to enhance the patient experience as well as for educational and training purposes, Prosthodontic Associates utilizes the use of photography as well as audio and video recording devices. The complete recordings and any information that could identify me will be kept confidential.

Signature:_____ **Date:**_____