PERSONAL HISTORY

Edentulous

Date _____

Name Miss Mrs. Mr. Dr. _____ Birth Date _____
SURNAME FIRST MIDDLE DAY MONTH YEAR

Residential Address _____
STREET CITY PROVINCE POSTAL CODE

Social Ins. No. _____ Residential Phone _____ Business Phone _____

Occupation _____ How Long Held _____ Marital Status _____

Employed By _____ Phone _____
FIRM ADDRESS

Name of Spouse _____ Occupation _____ How Long Held _____

Spouse Employed By _____ Phone _____
FIRM ADDRESS

Family Physician Dr. _____ Phone _____
NAME ADDRESS

May we request your health records if needed? _____

Whom may we thank for referring you to our office? _____

In case of an emergency, who should we notify? _____

Who is financially responsible for your account? _____

Name of Dental Insurance Co. If applicable _____

Have you had previous dental care under this plan? _____

Other _____

_____

_____

DENTAL HISTORY

The following information will help us render the best treatment for you. All information is, of course, confidential.

CHIEF COMPLAINT:

1. Are you having any discomfort or pain at this time? _____
2. Please state your concern for seeking treatment. _____

_____

_____

EVALUATION FOR TEMPOROMANDIBULAR DISORDERS:

1. Do you have any difficulty opening your mouth? _____
2. Can you easily yawn, open wide, bite easily into a sandwich and chew? _____
3. Do you have pain with the items in question 2? _____
4. Do you have pain in or about the ears or cheeks? _____
5. Do you hear noises from the jaw joints? _____
6. Does your jaw get “stuck”, “locked”, or “go out”? _____
7. Does your bite feel uncomfortable or unusual? _____
8. Do you usually chew on one side? _____
9. Are you aware of clenching or grinding your teeth during the day or night? _____
10. Do you have frequent headaches, neck or shoulder pain? _____

DENTAL HISTORY Cont'd

11. Have you ever had an injury to your jaw, head or neck? _____
12. Have you been under more than average nervous tension lately? _____
13. How often do you miss work due to illness? _____
14. Have you changed jobs, lost a family member or had another difficult experience within the last year? _____
15. Have you previously been treated for a temporomandibular disorder? _____

    If so, when? _____ How? _____ By whom? _____
16. Other _____

    _____

EVALUATION OF GENERAL HISTORY:

1. How many and what kind of dentures have you had? _____
2. In what year(s) were your first set of dentures made? _____
3. Have you been comfortable with your dentures? _____

    _____
4. How did you feel about the doctor(s) who made the dentures? _____

    _____
5. What was the date of extraction? _____
6. What was the reason for the loss of teeth? _____

    _____

    _____
7. Did you want your teeth extracted? _____
8. How did you feel about their loss? _____

    _____

    _____
9. Did you initially have removable, partial, or complete dentures? _____

    _____

    _____
10. Did you help to choose the front teeth? _____

    _____
11. What are the deficiencies of your dentures? _____

    _____
12. Do you have specific desires relative to the arrangement of your teeth? _____

    _____
13. What do you expect from these dentures? What would you like? _____

    _____
14. If you are having a denture problem, is it related to:

    Pain _____ Discomfort _____ Appearance _____ Function _____

FOR DOCTORS USE ONLY

ALLERGIES

MEDICAL HISTORY

FACTORS INFLUENCING TREATMENT

1. To the best of your knowledge, are you in good health? _____

2. a. Are you presently under treatment or observation by a physician? _____

   By whom _____ For what reason? _____

   b. Date of last complete physical examination _____

3. Are you taking any medications prescribed or self administered? _____

   Medications _____ For what reason? _____

   Medications _____ For what reason? _____

4. Have you experienced an unusual reaction to any of the following medications? _____

Penicillin	YES ☐	NO ☐	Other Antibiotics	YES ☐	NO ☐	Aspirin	YES ☐	NO ☐
Sulfa Drugs	YES ☐	NO ☐	Codeine	YES ☐	NO ☐	Local Anesthesia	YES ☐	NO ☐

   Other _____

5. Do you have any allergies? _____

6. Do you have or have you had any of the following:

		YES	NO			YES	NO
CVS	RHEUMATIC FEVER	___	___	LIVER DISEASE	CIRRHOSIS	___	___
	HEART MURMUR	___	___		JAUNDICE	___	___
	HEART DISEASE	___	___		HEPATITIS	___	___
	CHEST PAINS	___	___				
	SHORTNESS OF BREATH	___	___	G.I. DISEASE	FOOD INTOLERANCES	___	___
	SWELLING OF THE ANKLES	___	___		MEDICINE INTOLERANCES	___	___
					ULCERS	___	___
	ABNORMAL BLOOD PRESSURE	___	___				
	HEADACHES	___	___	ENDOCRINE	DIABETES	___	___
					THYROID PROBLEMS	___	___
BLOOD	TENDENCY TO BRUISE-BLEED EASY	___	___		WEIGHT LOSS IN SHORT PERIOD		
ABNORMALITIES	PROLONGED BLEEDING EPISODES	___	___		OF TIME	___	___
	BLOOD DISORDERS	___	___				
	HAD BLOOD TRANSFUSION	___	___	OCULAR DISEASES	GLAUCOMA	___	___
					FREQUENT EYE PROBLEMS	___	___
RESPIRATORY	SINUSITIS	___	___				
DISEASE	ASTHMA	___	___		VENEREAL DISEASE	___	___
	BRONCHITIS	___	___	SOCIAL DISEASES	HERPES	___	___
	TUBERCULOSIS	___	___				
					ARE YOU PREGNANT?	___	___
CNS	EPILEPSY	___	___	WOMEN ONLY	IF YES, IN WHAT STAGE OF		
	TENDENCY TO FAINT	___	___		PREGNANCY?	_____	
	FITS OR CONVULSIONS	___	___		ARE YOU TAKING ORAL		
	EXCESSIVE NERVOUSNESS	___	___		CONTRACEPTIVES OR		
					HORMONES?	___	___
KIDNEY DISEASE	RECURRING KIDNEY INFECTIONS	___	___				
	KIDNEY STONE	___	___	BLOOD PRESSURE	_____		
	VOID MORE THAN 6x/DAY	___	___				
	PROSTATE	___	___		_____		

7. Have you ever been hospitalized? YES ☐ NO ☐

YEAR	PURPOSE OF STAY	HOSPITAL	DOCTOR IN CHARGE

ADDITIONAL COMMENTS

_____

_____

a. I have read and answered the Personal, Dental, Medical histories and certify it to be complete and correct to the best of my knowledge.
b. It is understood that appliances, models, radiographs, and photographs taken in the examination and treatment of dental problems remain the property of the dentist.
c. Consent is given to the taking and use of photographs for scientific and educational purposes.

Patient Signature _____