



Denture Clinic

Creating Smiles by Design

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Name: _____ Date: _____

Medical History

Circle Appropriate Answers

Yes No Are you in good general health?
Yes No Are you now taking any drugs or medications?
Which ones? _____

Yes No Are you allergic to any medications?
Which ones? _____

Family Doctor: _____
Phone Number: _____

Yes No Would you object to our office contacting your family doctor in regard to any medical problem that may arrive?

Yes No Have you ever received local anesthesia (Novocaine or Xylocaine) by a dentist or doctor?

Yes No Have you ever received general anesthesia? Please describe: _____

Yes No Do you take blood thinners? Which ones? _____

Yes No Do you take vitamins regularly? Which ones? _____

Yes No Do you take vitamins containing Vitamin E?

Yes No Do you take aspirin products or anti-inflammatory medicines or headache medicines? Which ones? _____

Yes No Do you exercise regularly?

Please list all previous surgeries and dates:

Do any of your family members have the following? (Circle if yes.)

Heart trouble. Tuberculosis.
Excessive scarring. Excessive bleeding tendency.
Adverse reactions to anesthesia. Diabetes.
Psychiatric or "nerve" problems.

Yes No Blood pressure or related problems.
Yes No Liver, gallbladder, problems.
Yes No "Yellow Jaundice", Hepatitis problems.
Yes No Heart Trouble.
Yes No Kidney Disease.
Yes No Diabetes.
Yes No Stomach problems, indigestion or ulcers.
Yes No Bleeding tendency or excessive bruising.
Yes No Any part of your body paralyzed or numb.
Yes No Psychiatric consultation.
Yes No Epilepsy-convulsions or seizures.
Yes No Broken bones of the face, neck, jaw or back.
Yes No Back trouble.
Yes No Abnormal chest x-rays.
Yes No Abnormal Electrocardiogram. (ECG)
Yes No Asthma or respiratory problems.
Yes No Any medical treatment for nervous condition.
Yes No Excessive scarring.
Yes No Tuberculosis.
Yes No Thyroid problems.
Yes No Any other illnesses. If so please list:

Yes No A gain or loss of more than 15 pounds in your body weight.
Yes No Abdominal or inguinal hernia.
Yes No History of blood clots in legs or lungs.
Yes No History of legs swelling.
Yes No Glaucoma, cataracts.
Yes No Dry eyes.
Yes No Herpes or Cold Sores.

Other: _____

Do You:

Yes No Wear contact lenses?
Yes No Have dentures, false teeth, caps or bridges?
Yes No Smoke? How much?
Yes No Drink alcohol? How much?
Yes No Think you are pregnant? Date of last menstrual period?
Yes No Have any contagious or infectious conditions?
Yes No Have you been exposed directly or indirectly to any one with HIV (AIDS)

The above information is strictly confidential.

Patient Signature: _____ Date: _____ Witness Signature: _____ Date: _____