Medical History

Circle

1. Are you being treated for any medical conditions at present or within the past 5 years? **Yes** **No**

   If yes, please explain____

   ____

2. Have you been injured or hospitalized in the last 2 years? **Yes** **No**

   If yes, please explain____

   ____

3. Have you recent, or are you presently taking any prescription/non-prescription medications? **Yes** **No**

   If yes, please explain____

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4. Do you suffer from Dry Mouth? **Yes / No**
5. Do you have allergies to plastics? **Yes / No**
6. Is there a family history of diabetes, heart disease, cancer or osteoporosis? **Yes / No**
7. Do you bleed excessively from a cut or do you bruise easily? **Yes / No**
8. Has your weight, appetite or energy level changed dramatically, recently? **Yes / No**
9. Do you follow a special diet? **Yes / No**
10. Do you smoke? **Yes / No**
11. Have you tested HIV positive? **Yes / No**
12. Have you tested positive for Hepatitis A B C? **Yes / No**
13. Do you wish to speak privately to the Denturist about any medical condition? **Yes / No**

Do you have / or have you had any of the following:

- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ COPD
- ☐ Diabetes
- ☐ Emphysema
- ☐ ________________
- ☐ Fibromyalgia
- ☐ Head/Neck Injury
- ☐ Heart Disease
- ☐ High/Low Blood Pressure
- ☐ High Cholesterol
- ☐ Hyper/Hypoglycemia
- ☐ Lupus
- ☐ Migraines
- ☐ Parkinson's Disease
- ☐ Radiation/Chemotherapy
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thrush
- ☐ Thyroid Disorder
- ☐ TMJ Disorder
- ☐ Tuberculosis
- ☐ Sexually Transmitted Disease (STD)

I, the undersigned, hereby certify the information given by me to be accurate, and I assume responsibility for all fees incurred.

Patient signature: ______________________________________ Date: ____________________