BG DENTURE & IMPLANT RESTORATIVE CENTRE

DENTURE HISTORY - Patients with dentures

1. Functional complaint about dentures

1.1	Have you had trouble pronouncing any words due to your denture?	Yes	No
1.2	Did your taste change because of your denture?	Yes	No
1.3	Does your denture cause pain or sore spots when wearing?	Yes	No
1.4	Does you denture cause pain or sore spot when eating?	Yes	No
1.5	Does your denture loosen easily when eating?	Yes	No
1.6	Does your denture loosen easily when talking?	Yes	No
1.7	Does it feel difficult to swallow liquid food?	Yes	No
1.8	Do you feel food impact under your denture easily?	Yes	No
1.9	Does it feel difficult to open your mouth when wearing your denture?	Yes	No
1.10	Do you have full mouth sensation due to your denture?	Yes	No
1.11	Do you find your denture or teeth clicking when eating or talking?	Yes	No
1.12	Did you find your face changed when you were wearing your denture?	Yes	No
1.13	Do you bite your cheek or tongue mucosa easily?		
	Score 1 – 4 (1 = never; 2 = sometimes; 3 = often 4 = always)	1 2 3 4	

2. Overall masticating ability

2.1	Do you experience difficulty when chewing?	Yes	No
2.2	Do you have problems with drooling?	Yes	No
2.3	Do you take out your denture for eating?	Yes	No
2.4	Do you feel insecure with your denture when eating?	Yes	No
2.5	Has your diet been unsatisfactory because of your denture?	Yes	No
2.6	Have you had to interrupt your meal because of your denture?		
	Score 1 – 4 (1 = never; 2 = sometimes; 3 = often 4 = always)	1 2 3 4	

3. Masticating ability for different types of food

3.1	Can you eat hard food with your denture?	Yes	No
3.2	Can you eat soft food with your denture?	Yes	No
3.3	Can you eat tough food with your denture?		
	Score 1 – 4 (1 = never; 2 = sometimes; 3 = often 4 = always)	1 2 3 4	

4. Effect on mental and daily life

4.1	Do you feel tense when wearing you denture?	Yes	No
4.2	Do you find it difficult to relax because of your denture?	Yes	No
4.3	Do you feel embarrassed when wearing your denture?	Yes	No
4.4	Do you get upset by the appearance of your profile?	Yes	No
4.5	Have you been irritable with others because of problems with your denture?	Yes	No
4.6	Do you have difficulty in your daily job because of problems of your denture?	Yes	No
4.7	Are you afraid to go out with others because of problems with your denture?		
	Score 1 – 5 (1 = never; 2 = hardly ever; 3 = occasionally 4 = fairly often; 5 = very often)		
		1 2 3 4 5	

5. Overall denture satisfaction

5.1	How many times do you take out your prosthesis because of discomfort?	_____
5.2	How satisfied are you with your upper denture?	_____
5.3	How satisfied are you with your lower denture?	_____

5.4 How satisfied are you in general with your dentures? _____

5.5 How satisfied are you with the functional comfort of your denture? _____

5.6 How satisfied are you about eating with your denture? _____

5.7 How satisfied are you about speaking with your denture? _____

5.8 Were your expectations for your new prosthesis satisfied? Yes No

5.9 Would you repeat the same treatment? Yes No

HEALTH HISTORY

Physician's Name_____ Date of last visit: _____

Have you ever taken any of the group drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

Yes No

Circle "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Hepatitis Type	Yes	No
Anemia	Yes	No	Herpes	Yes	No
Arthritis, Rheumatism	Yes	No	High Blood Pressure	Yes	No
Artificial Heart Valves	Yes	No	Mitral Valve Prolapse	Yes	No
Artificial Joints	Yes	No	Nervous Problems	Yes	No
Asthma	Yes	No	Pacemaker	Yes	No
Back Problems	Yes	No	Psychiatric Care	Yes	No
Bleeding abnormally, with extractions	Yes	No	Radiation Treatment	Yes	No
or surgery	Yes	No	Respiratory Disease	Yes	No
Blood Disease	Yes	No	Rheumatic Fever	Yes	No
Cancer	Yes	No	Scarlet Fever	Yes	No
Chemical Dependency	Yes	No	Shortness of Breath	Yes	No
Chemotherapy	Yes	No	Sinus Trouble	Yes	No
Circulatory Problems	Yes	No	Skin Rash	Yes	No
Congenital Heat Lesions	Yes	No	Special Diet	Yes	No
Cortisone Treatments	Yes	No	Stroke	Yes	No
Cough, persistent of bloody	Yes	No	Swollen Feet or Ankles	Yes	No
Diabetes	Yes	No	Swollen Neck Glands	Yes	No
Emphysema	Yes	No	Thyroid Problems	Yes	No
Epilepsy	Yes	No	Tonsillitis	Yes	No
Fainting or dizziness	Yes	No	Tuberculosis	Yes	No
Glaucoma	Yes	No	Tumor or growth on head or neck	Yes	No
Headaches	Yes	No	Ulcer	Yes	No
Heart Murmur	Yes	No	Venereal Disease	Yes	No
Heart Problems	Yes	No	Weight Loss, unexplained	Yes	No

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No Due date: _____

Are you nursing? Yes No Taking birth control pills? Yes No

Medications
List any medications you are currently taking and the correlating diagnosis: _____

_____

_____

Pharmacy Name: _____
Phone: _____

Allergies

Aspirin	☐	Iodine	☐	Penicillin	☐
Barbiturates (Sleeping pills)	☐	Latex	☐	Sulfa	☐
Codeine	☐	Local Anesthetic	☐	Other	☐

UPDATES

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? If so, what? _____

_____

Patient's Signature _____

Doctor's Signature _____

DENTAL HISTORY - Patients with natural teeth only

Chief oral complaints: _____ Date of last dental exam: _____

Have you had any major dental treatment? If so when: _____

What was done? _____

Do you have or do you use any of the following? Indicate with an "X"

Sensitivity to Hot/Cold, Sweets or Pressure	☐	Mouth. Night Guard	☐
Bleeding Gums, How long?	☐	Frequency of Brushing #: _____	
Food Impaction	☐	Oral Habits i.e.: Fingernail biting, Gag reflexes	☐
Clenching or Grinding	☐	Would you life to discuss improving the	
Burning of Tongue	☐	appearance of you teeth and/ or smile?	☐
Swelling of Lumps in Mouth	☐	Unpleasant taste	☐
Frequent Blisters on Lips or in Mouth	☐	Inter Dental Stimulators	☐
Pain around the Ear	☐	Retainers. Removable Appliances	☐
Dental Floss, How often? _____		Disclosing Tablets or Solutions	☐
Dry Mouth	☐	Fluoride Supplements	☐
Bad Breath	☐	Teeth Whitening Products	☐
Unfavorable Dental Experience	☐	Sleep Devices	☐
Complications from Extractions	☐	Cigarette, pipe or cigar smoking	☐
Periodontal Treatment	☐	Teeth Implants	☐
Mouth Breathing or snoring	☐		☐

Please write anything you feel will be helpful in allowing us to personalize you care: _____

_____