Saskatoon Denture Clinic Ltd.

Original Date: _____

COMPLETE & PARITAL DENTURE SERVICES

JAMES G. HOFFART DD Licensed Denturist CHELSEA B. SCHREINER DD Licensed Denturist

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential!

Name *(Last, First):* _____ ◯ M ◯ F **Date of Birth:** _____

Marital status: ◯ Single ◯ Partnered ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Phone: Residence: _____ **Cell:** _____ **Business:** _____

Address: Street: _____ **City:** _____ **Province:** _____

Postal Code: _____ **Email:** _____

Referred by: _____

INSURANCE INFORMATION

Health Card Number: _____ **First Nations Client ID #:** _____

Primary Insurance Company: _____

Plan Member/Subscriber Name: _____ D.O.B. _____

Group/Plan Number: _____ I.D./Certificate Number: _____

Secondary Insurance Company: _____

Plan Member/Subscriber Name: _____ D.O.B. _____

Group/Plan Number: _____ I.D./Certificate Number: _____

DENTURE INFORMATION

Complete the following information if you have a partial &/or complete denture or dentures

Age of present dentures: **Upper:** _____ ◯ **Month(s)** ◯ **Year(s)** **Lower:** _____ ◯ **Month(s)** ◯ **Year(s)**

Present denture was made by: _____ ☐ **Unknown/ Prefer not to say**

What type of dentures do you have? **Upper:** ◯ **Partial** ◯ **Complete**

Lower: ◯ **Partial** ◯ **Complete**

Last denture procedure (ex. reline, repair, etc): _____ **Date:** _____

How many dentures have you had (if applicable)? **Upper:** _____ **Lower:** _____

Do you wear your dentures at night (if applicable)? **Upper:** ◯ **Yes** ◯ **No** **Lower:** ◯ **Yes** ◯ **No**

Do you brush your gums under your denture(s)? **Upper:** ◯ **Yes** ◯ **No** **Lower:** ◯ **Yes** ◯ **No**

Do your gums get sores under your dentures? **Upper:** ◯ **Yes** ◯ **No** **Lower:** ◯ **Yes** ◯ **No**

If yes, how often do the sores appear? ◯ **Occasionally** ◯ **Daily** ◯ **Weekly** ◯ **Other** **If other, please specify:** _____

Are you happy with the appearance of your dentures ◯ **Yes** ◯ **No**

Do you have problems eating any particular types of food? ◯ **Yes** ◯ **No** **If yes, please specify:** _____

Have the benefits of dental implants been discussed with you? ◯ **Yes** ◯ **No**

DENTAL INFORMATION

Complete the following information if you have some or all of your natural teeth

Personal Dentist: _____ **Phone number:** _____

When was your last dental visit? _____

What procedures did you have done at that visit? _____

How often do you brush your teeth? ◯ Daily ◯ Weekly ◯ Other **If other, please specify:** _____

How often do you floss your teeth? ◯ Daily ◯ Weekly ◯ Other **If other, please specify:** _____

How often do you see a Hygienist? ◯ Monthly ◯ Semi-Annually ◯ Annually ◯ Other
If other, please specify: _____

Select yes or no for the following questions

Have you had any complications following a dental procedure? ◯ Yes ◯ No **If yes, please specify:** _____

Have you had dental x-rays done in the last two (2) years? ◯ Yes ◯ No

Do you have any dental work ongoing at this time? ◯ Yes ◯ No

Do you have any outstanding dental work to be done? ◯ Yes ◯ No **If yes, please specify:** _____

Do you have any sensitive teeth? ◯ Yes ◯ No

Do your gums bleed (if applicable)? ◯ Yes ◯ No

Do you normally have an unpleasant odour/taste in your mouth? ◯ Yes ◯ No

Do you have any pain in your jaw joint? ◯ Yes ◯ No

Do you clench or grind your teeth? ◯ Yes ◯ No

Do you have dental implants? ◯ Yes ◯ No **If yes, please specify:** _____

Have you ever had an accident or had trauma/injury to your neck or jaws? ◯ Yes ◯ No **If yes, please specify:** _____

Do you have any pain or numbness in your head, neck or jaws? ◯ Yes ◯ No **If yes, please specify:** _____

Do you have any sore spots or abnormalities in your mouth? ◯ Yes ◯ No

Do you have any habits which affect your mouth (mouth breathing, chewing objects, etc)? ◯ Yes ◯ No **If yes, please specify:**

Have you been diagnosed with Sleep Apnea? ◯ Yes ◯ No **If yes, by whom?** _____

Do you have any other dental health issues which have not been addressed above?

_____

MEDICAL HISTORY

Select yes or no for the following questions

Are you taking any medications, over the counter medications, or herbal remedies ◯ Yes ◯ No

If yes, please specify (type and purpose): _____

Are you allergic to any medications? ◯ Yes ◯ No
If yes, please specify: _____

Are you allergic to any foods, metals or latex? ◯ Yes ◯ No
If yes, please specify: _____

Have you recently lost or gained a significant amount of weight? ◯ Yes ◯ No
If yes, how much? _____

Do you smoke or use chewing tobacco? ◯ Yes ◯ No
If yes, type & how long? _____

Do you frequently have indigestion? ◯ Yes ◯ No

Do you take medication for indigestion? ◯ Yes ◯ No
If yes, please specify: _____

Are you pregnant (if applicable)? ◯ Yes ◯ No

Check if you have, or have had, any of the following conditions:

☐ Drug dependency	☐ Tuberculosis	☐ Artificial heart valve
☐ Environmental allergies	☐ Hepatitis A	☐ Pacemaker
☐ Food allergies	☐ Hepatitis B	☐ Angina Pectoris
☐ Latex allergy	☐ Hepatitis C	☐ Cholesterol problems
☐ Other allergies:	☐ Other liver disease:	☐ High blood pressure
☐ HIV/Aids	☐ Arthritis	☐ Low blood pressure
☐ Sexually transmitted disease	☐ Diabetes Type 1	☐ Menopause
☐ Immune deficiency	☐ Diabetes Type 2	☐ Sinusitis
☐ Herpes virus (cold sores)	☐ Epilepsy or seizures	☐ Thyroid disorder
☐ Kidney disease	☐ Dizziness/fainting	☐ Gastrointestinal disorder
☐ Kidney stones	☐ Heart attack	☐ Dry mouth
☐ Asthma	☐ Heart disease	☐ Anemia
☐ Chronic Obstructive Pulmonary disease	☐ Rheumatic Fever	☐ Chronic headaches
☐ Difficulty breathing	☐ Heart Murmur	☐ Facial muscle pain
☐ Emphysema	☐ Heart Surgery	☐ Other(s), please specify:
☐ Artificial joint replacement If yes,	please specify:	
☐ Eating disorder If yes,	please specify:	
☐ Nervousness/Psychiatric condition If yes,	please specify:	
☐ Cancer If yes,	please specify:	
☐ Chemotherapy/Radiation therapy		

Additional medications/allergies/operations/ or relevant medical history

"I the undersigned, hereby certify that all of the medical and dental information provided on this form to be true to the best of my knowledge and that I have not knowingly omitted any information. I also consent to my family physician/family dentist being contacted, if necessary, to obtain further information or clarification of medical/dental conditions as is necessary for my denturist treatment."

Patient Signature: _____ **Date:** _____