RECORD RIDGE DENTURE CLINIC

MEDICAL HISTORY FORM

(Please Print)

PATIENT MEDICAL HISTORY

1. Are you being treated for any medical condition at present or within the past 5 years? If yes, please explain:

2. Please list any prescription/non-prescription medications you are currently using or have recently used:

3. Do you have any allergies causing anaphylactic reactions? Please list:

4. Are you allergic to the following: ❑ Latex Gloves ❑ Metals ❑ Plastics

5. Do you bleed excessively from a cut or do you bruise easily?	❑ Yes ❑ No
6. Has your weight changed dramatically recently?	❑ Yes ❑ No
7. Do you smoke?	❑ Yes ❑ No
8. Are you HIV positive or do you have AIDS?	❑ Yes ❑ No
9. Have you tested positive for Hepatitis A B or C? (Indicate which)	❑ Yes ❑ No
10. Do you wish to speak privately with the denturist about any medical condition?	❑ Yes ❑ No

11. Indicate below if you have a history of any of the following:

❑ Alzheimer's	❑ Thyroid Disorder	❑ Radiation/Chemotherapy
❑ Anemia	❑ Head/Neck Injury	❑ Rheumatic Fever
❑ Arthritis	❑ Heart Disease	❑ Stroke
❑ Blood Transfusion	❑ High/Low Blood Pressure	❑ Thrush
❑ Cancer	❑ Hodgkin's Disease	❑ TMJ Disorder
❑ Diabetes	❑ Hypo/Hyperglycemia	❑ Tuberculosis (TB)
❑ Emphysema	❑ Lupus	❑ Sexually Transmitted Diseases
❑ Epilepsy/Seizures	❑ Migraines	❑ _____
❑ Fibromyalgia	❑ Parkinson's Disease	❑ _____

CONSENT

I, _____, hereby certify the information I am providing to be
Please print
accurate, and I assume responsibility for all fees incurred.

Patient signature	*Date*