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DENTURE HEALTH HISTORY

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Place Of Employment: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ Referred To Us By: \_\_\_\_\_  
Dental Insurance Co. Name: \_\_\_\_\_  
Most Convenient Day & Time For Your Dental Appointments: \_\_\_\_\_  
Purpose of This First Dental Visit: \_\_\_\_\_

Person Financially Responsible For This Account: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Employment Name & Address: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Please check the best answer, and complete the blank lines where appropriate:

- Are you under any medical treatment now or within the past 5 years? . . . . . Yes \_\_\_ No \_\_\_  
If YES, for what problems? \_\_\_\_\_
- Have you ever had treatment for your gums? . . . . . Yes \_\_\_ No \_\_\_
- Has worry ever kept you from seeking dental care? . . . . . Yes \_\_\_ No \_\_\_
- Are you allergic or sensitive to any medications? . . . . . Yes \_\_\_ No \_\_\_
- Are you continually troubled with bad spells of sneezing, stuffed-up nose, hayfever, etc.? . . . . Yes \_\_\_ No \_\_\_
- Would wearing false teeth disturb you greatly? . . . . . Yes \_\_\_ No \_\_\_
- Has a physician ever said your blood pressure was too low, or too high? . . . . . Yes \_\_\_ No \_\_\_  
If YES, which one? . . . . . High \_\_\_ Low \_\_\_
- Do you suffer from constant stomach trouble? . . . . . Yes \_\_\_ No \_\_\_
- Are you taking any medication? If YES, please list \_\_\_\_\_ Yes \_\_\_ No \_\_\_
- Are you considered a nervous person? . . . . . Yes \_\_\_ No \_\_\_
- Would you like to know more about implants to stabilize dentures? . . . . . Yes \_\_\_ No \_\_\_
- Have you frequently been confined to bed? . . . . . Yes \_\_\_ No \_\_\_
- Have you gained or lost much weight lately? . . . . . Yes \_\_\_ No \_\_\_
- Have you ever had a series of injections other than for immunization purposes?
- Do you smoke? . . . . . Yes \_\_\_ No \_\_\_
- Are you constantly keyed-up and jittery? . . . . . Yes \_\_\_ No \_\_\_
- Has a physician ever said that you had: stomach ulcers, diabetes, tuberculosis, rheumatic fever, cancer, anemia, kidney, bladder, lever or heart trouble, bleeding disorders, hepatitis, asthma, immune system diseases, communicable diseases?  
If YES, please list: \_\_\_\_\_
- Have you had any mojour operations in the last 10 years? . . . . . Yes \_\_\_ No \_\_\_
- Do you suffer from frequent or sick headaches? . . . . . Yes \_\_\_ No \_\_\_
- How long since you have had a complete physical examination? . . . . . Yes \_\_\_ No \_\_\_

Do you have any particular mouth habits listed among the following? Please circle which ones apply.  
Foreign objects between teeth? • Biting lips, cheek, tongue, fingernails? • Clenching teeth? • Grinding teeth at night? •  
Awake in morning with teeth together? • Aches in joint-face muscles? • Ear problems?  
Other: \_\_\_\_\_