Iman Abdeshahian, DMD

Denture New Patient Form

Dental Wellness Center
5406 E. Village Road
Long Beach , CA , 90808

(562) 421-3747
www.LongBeachHolisticDentist.com
leanne@LBDWC.com

Last Name _____ First Name _____ Middle Name _____ Appointment date: _____

Prefer to be called: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Ph. _____ Bus. Ph. _____ Usual Ph: _____

Referred by: _____

Personal History

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced How long? _____

Hobbies: _____ Social activities: _____

Present Pursuit(s): _____

Recent life changes? _____

Children: _____ Grandchildren: _____

Height: _____ Weight: (present) _____ (usual): _____ Exercise: _____ Sleep: _____

Liquid Intake/day: _____ Diet: _____

Alcohol: _____ Tobacco: _____ Chewing habits: _____

Contact lenses (progressive lenses) ☐ Yes ☐ No How well tolerated? _____

Medical History

The thoroughness of this medical history is designed for your safety, and your complete answers will assist us in treating you with consideration for your special needs.

Family Physician: _____ Date of last visit: _____

Specialty: _____ Date of last complete physical: _____

Address: _____

City: _____ State: _____ Zip Code: _____ (Area Code) Phone # _____

Additional Physician: _____ Date of last visit: _____

Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____ (Area Code) Phone # _____

Additional Physician or Health Provider, such as Chiropractor, Naturopath, Homeopath, Acupuncturist, etc.

_____ Date of last visit: _____

Address: _____

City: _____ State: _____ Zip Code: _____ (Area Code) Phone # _____

Please check YES or NO.

1. Do you have a current medical problem? ☐ Yes ☐ No
   If yes, please explain: _____
2. Are you currently under the care of a physician? ☐ Yes ☐ No
   If yes, who? _____
3. Have you been hospitalized or had a serious illness within the past 5 years? ☐ Yes ☐ No
   If YES, please explain: _____
4. Do you have heart trouble or any form of cardiovascular disease? ☐ Yes ☐ No
   If YES, indicate below:
   - ☐ Angina (chest pains) Frequency _____
   - ☐ Heart Attack (date) _____
   - ☐ Heart Surgery (date) _____
     - ☐ Pacemaker
     - ☐ Bypass
     - ☐ Prosthetic heart valve
   - ☐ Stroke (date) _____
   - ☐ Blood Pressure, if known _____
   - ☐ Rheumatic Fever (date) _____
   - ☐ Heart Murmur
   - ☐ High Blood Pressure
   - ☐ Low Blood Pressure
   - ☐ Congenital Heart lesions
   - ☐ Atherosclerosis
   - ☐ Other: _____
5. Are you ever short of breath after mild exercise? ☐ Yes ☐ No
6. Do your ankles swell? ☐ Yes ☐ No
7. Do you get short of breath when you lie down, or do you require extra pillows when you sleep? ☐ Yes ☐ No
8. Do you have diabetes? ☐ Yes ☐ No Prediabetes? ☐ Yes ☐ No
   If YES, how is it controlled ☐ Diet ☐ Oral Medication ☐ Injections
9. Do you have hypoglycemia? ☐ Yes ☐ No
   If YES, how is it controlled? _____
10. Do you have kidney disease? ☐ Yes ☐ No
11. Have you ever had hepatitis? ☐ Yes ☐ No
    If YES, Date? _____
    ☐ Type A Infectious (Food) ☐ Type B Serum (Blood) ☐ Type C (non-A, non-B) ☐ Unknown
    If Unknown, Explain: _____
12. Have you ever had liver disease or jaundice? ☐ Yes ☐ No
    If YES, Date: _____
13. Do you have any blood disease? ☐ Yes ☐ No
    ☐ Anemia ☐ AIDS or HIV positive test ☐ Leukemia ☐ Venereal disease
    ☐ Other: _____
14. Do you have any problems with excessive bleeding? ☐ Yes ☐ No
    If YES, please explain: _____
15. Do you bruise easily? ☐ Yes ☐ No
16. Do you have stomach or intestinal ulcers? ☐ Yes ☐ No
17. Have you ever had tuberculosis? ☐ Yes ☐ No
    If YES, Date: _____
18. Do you have emphysema, asthma or breathing problems? ☐ Yes ☐ No

Please check YES or NO.

19. Do you have any form of arthritis? ☐ Yes ☐ No
☐ Rheumatoid Arthritis ☐ Gout/Gouty Arthritis ☐ Osteoarthritis
☐ Other: _____
Which joints are involved? _____

20. Do you have any orthopedic or tissue repair implants in your body such as pins, plates, screws or artificial joints? ☐ Yes ☐ No
If yes, please list them as best you can: _____

21. Do you have fainting spells, convulsions or epilepsy? ☐ Yes ☐ No

22. Have you had surgery, radiation or treatment for a tumor or growth? ☐ Yes ☐ No
If YES, what area(s)? _____

23. Do you have glaucoma? ☐ Yes ☐ No
☐ Right eye ☐ Left eye ☐ Both eyes

24. Your height: _____

25. Current body weight: _____ Have you gained ☐ or lost ☐ weight within the last year?
How much? _____

26. Is your diet medically prescribed? ☐ Yes ☐ No
If YES, please explain. _____

27. Are you taking vitamins? ☐ Yes ☐ No
What kind and dosages? _____

28. Are you currently taking any herbal medicines? ☐ Yes ☐ No
If so, what kind? _____

29. Are you using food supplements? ☐ Yes ☐ No
What? _____

30. Do you frequently not eat breakfast? ☐ Yes ☐ No

31. Do you become fatigued easily? ☐ Yes ☐ No
At what time of day? _____

32. Have you been told, or are you aware that you have a tendency for snoring? ☐ Yes ☐ No

33. Do you feel rested after 7 hours of sleep? ☐ Yes ☐ No

34. Are you sleepy or do you feel you are dragging during the day? ☐ Yes ☐ No

Questions 35-36 are For Women Only

35. Is there a possibility that you may be pregnant? ☐ Yes ☐ No
If so, expected delivery date: _____

36. Do you have a history of miscarriages? ☐ Yes ☐ No

37. Are you allergic to or have you had any unusual reaction to any of the following? ☐ Yes ☐ No

☐ Penicillin
☐ Erythromycin
☐ Sulfa drugs
☐ Codeine
☐ Aspirin
☐ Sleeping pills
☐ Barbiturates
☐ Other antibiotics: _____

☐ Local anesthetics
☐ Novocain
☐ Xylocaine
☐ Nitrous oxide
☐ Epinephrine
☐ Other pain medications: _____
☐ Any other drug allergies? _____

Please check YES or NO.

38. Do you have a current medical problem? ☐ Yes ☐ No
If YES, please list: _____

39. Have you ever been advised to take prophylactic antibiotics before dental treatment? ☐ Yes ☐ No

40. Have you ever used Phen Fen or other appetite suppression combinations for weight loss? ☐ Yes ☐ No
If the answer to question #40 is positive, have you had an echocardiogram? ☐ Yes ☐ No

41. Are you taking/have you taken bisphosphonate medication (Zometa, Fosomax, Didronel, Actonel, Aclasta?) ☐ Yes ☐ No
If so, for how long/how long ago? _____

Please indicate if you are taking any of the following medications:

	Name	Purpose	Frequency	Since
☐ Heart Medication				
☐ Blood Pressure Medication				
☐ Cholesterol lowering				
☐ Insulin				
☐ Nitroglycerine				
☐ Blood Thinner Medication				
☐ Antibiotics				
☐ Sedatives				
☐ Tranquilizers				
☐ Anti Depressants				
☐ Pain Medication				
☐ Cortisone (Steroids)				
☐ Thyroid				
☐ Birth Control Pills				
☐ Over Counter Medications				
☐ Medicinal Patches				
☐ Other: _____				

Please name the pharmacy you use. _____ City: _____ Phone: _____

☐ Alcohol _____ drinks per day

☐ Tobacco _____ packs per day for approximately _____ years

☐ "Recreational" drugs such as cocaine, marijuana, stimulants or depressants may have a fatal interaction with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor.

42. Is there a disease, condition or problem not listed above that you think I should know of? ☐ Yes ☐ No
If yes, what? _____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff, and I will assume financial responsibility.

Signature: _____ Date: _____

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Iman Abdeshahian, DMD

Dental History

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Reasons for previous extractions: _____

Date of most recent extractions: _____

Complications? _____

Did you wear partial dentures prior to having all teeth removed? ☐ Yes ☐ No

If yes, how long? _____ How many? _____

Were your partial denture experiences positive? _____ Negative? _____

If negative, why? _____

1st Full Denture(s): Seating Date: _____ Placed same day as extractions? _____

Length of time 1st dentures worn? _____

Subsequent Dentures

Dates	Reasons for replacement

Which ones are you wearing now? _____

Main reason for having new dentures:

☐ Difficulty in chewing

☐ Discomfort

☐ Esthetics