Current as at:

Welcome to Sydney Prosthodontics

Medical and Dental History

REFERRED BY:.....

Patient Information

Title ..... First Name ..... Last Name ..... Date of Birth .....

Residential Address ..... Mailing Address (if applicable) .....

Occupation ..... Emergency, contact: ..... (*relationship*) ..... Telephone number of Emergency Contact .....

Contact Preferences *(please tick the preferred contact number - SMS notification available)*

Email .....

☐ Home .....

☐ Work .....

☐ Mobile .....

ALLERGIES

	Yes	No
Latex sensitivity	☐	☐
Penicillin	☐	☐
Other antibiotics	☐	☐
Aspirin	☐	☐
NSAIDS - Non steroidal anti-inflammatories	☐	☐
Codeine	☐	☐
x .....Other Allergies	☐	☐

MEDICATIONS

Please list any medication you are currently taking below:

Medications

	Yes	No
Are you on medications for osteoporosis	☐	☐

Is there anything else you feel we should be aware of?

DATE OF LAST COMPREHENSIVE EXAMINATION:

.....

HAVE YOU HAD OR DO YOU CURRENTLY HAVE....

	Yes	No
Artificial/prosthetic joints	☐	☐
Heart valve replacement/mitral valve	☐	☐
Rheumatic fever	☐	☐
Heart murmur	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Cardiac pacemaker	☐	☐
Other heart related problems	☐	☐
Snoring / Sleep apnoea	☐	☐
Asthma	☐	☐
Do you smoke	☐	☐
Anaemia / Other blood disorders	☐	☐
Bleeding tendency /abnormal bleeding	☐	☐
Hepatitis / Jaundice / Liver disease	☐	☐
Epilepsy or seizures	☐	☐
Thyroid trouble	☐	☐
Diabetes	☐	☐
Stomach ulcers	☐	☐
HIV/AIDS	☐	☐
Problem with your immune system	☐	☐
Removable partial denture	☐	☐
Does your jaw click or hurt	☐	☐
Do you feel you grind your teeth	☐	☐
Do you wear a night guard	☐	☐
Jaw muscle pain	☐	☐
Do you experience bad breath	☐	☐
Have you ever had gum disease	☐	☐
Brushing makes your gums bleed	☐	☐
Does food get jammed in your teeth	☐	☐
Does floss tear between your teeth	☐	☐
Any hot/cold sensitivity	☐	☐
Do your teeth hurt on hard biting	☐	☐

I have accurately completed this pre-clinical questionnaire to the best of my knowledge. I hereby give my authority for the dentist or designated team to take x-rays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis. Upon such a diagnosis I authorise the dentists to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Signature (Parent or Guardian if patient is a minor) ..... Date Signed .....

All information provided is confidential and covered by the Commonwealth Privacy Act 2001