ADVANCED DENTAL PROSTHETICS

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PROSTHODONTIST

HEALTH HISTORY

PT NAME _____ DOB _____ DATE _____

1) Are you under a physician's care now? Yes No If Yes _____
Hospitalization or major operation? Yes No If Yes _____
Have you ever taken Fosamax, Boniva, or any other medications containing bisphosphonates? Yes No If Yes _____

2) Are you taking or have you recently taken any prescription, OTC or herbal mediation? YES NO
If yes, please list here:

3) Are you ALLERGIC to or have you reacted adversely to any of the following medications?

Apspirin	YES	NO	Latex	YES	NO
Codeine	YES	NO	Metal	YES	NO
Penicillin	YES	NO	Sulfa Drugs	YES	NO
Local Anesthetics	YES	NO	Acrylic	YES	NO

4) Do you have or have you had ANY of the following:

Yes	No	Heart Disease	Yes	No	Ulcers	Yes	No	Epilepsy
Yes	No	Heart Surgery	Yes	No	Diabetes	Yes	No	Fainting/Seizures
Yes	No	Congenital Heart Lesions	Yes	No	Thyroid Problems	Yes	No	Persistant Headaches
Yes	No	Heart Arrythmia	Yes	No	Arthritis	Yes	No	Anemia
Yes	No	Pacemaker/Defibrillator	Yes	No	Joint Replacement	Yes	No	Abnormal Bleeding
Yes	No	High Blood Pressure	Yes	No	Osteoporosis	Yes	No	Bruise easily
Yes	No	Stroke/TIA	Yes	No	Tumor/Growths	Yes	No	AIDS/HIV
Yes	No	Respiratory Problems	Yes	No	Radiation/Chemo			Women Only:
Yes	No	Asthma	Yes	No	Alcoholism/Drug Abuse	Yes	No	Are you pregnant
Yes	No	Persistant Cough	Yes	No	Nervousness	Yes	No	Contraceptives
Yes	No	Hay Fever/Allergies	Yes	No	Glaucoma	Yes	No	Reached Menopause
Yes	No	Sinus Problems	Yes	No	Hepititis/Jaundice	Yes	No	Hormone Replacement

DENTAL HISTORY

1) What brings you to see us today? _____
2) Do you see a dentist regularly? Yes No Dentist Name _____
3) Date of last dental exam & cleaning? _____
4) If you could change anything about the appearance of your teeth, what woud it be? _____
5) Do you or have you had any of the following:

Yes	No	Mouth Discomfort	Yes	No	Tired Jaw or Facial Muscles	Yes	No	Difficulty Chewing
Yes	No	Bleeding Gums	Yes	No	Bad Taste or Bad Breath	Yes	No	Grinding/Clenching Teeth
Yes	No	Sentive Teeth	Yes	No	Complications with Dental Treament			

CONSENT FOR TREATMENT

I HEREBY AUTHORIZE THE DOCTOR OR HIS DESIGNEE TO UTILIZE VARIOUS DIAGNOSTIC AIDS, MEDICATIONS, AND THERAPY THAT ARE DEEMED NECESSARY OR ADVISABLE FOR DIAGNOSIS AND TREATMENT. I ALSO UNDERSTAND THAT THERAPEUTIC PROCEDURES MAY INVOLVE CERTAIN RISKS.

_____ _____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DENTIST SIGNATURE DATE