WEST DENTAL IMPLANTS & PROSTHETICS

Name _____

Medical Physician _____

Do you see your doctor for routine checkups? ☐ No ☐ Yes When was your last visit? _____

Have you ever been diagnosed with any of the following:

☐ Endocrine Disease	☐ Tuberculosis	☐ Lung disease	☐ Osteoporosis/Osteopenia
☐ Measles	☐ Hepatitis (A, B, C, D)	☐ Ulcers	☐ Hypertension
☐ Mumps	☐ Heart Disease	☐ Diabetes	☐ Venereal Disease
☐ Chicken Pox	☐ Heart Attack	☐ AIDS	☐ Cancer
☐ Asthma	☐ Heart Murmur	☐ Bleeding Disorder	☐ Rheumatic Fever
☐ Epilepsy	☐ Angina	☐ Emotional Disease	☐ Liver Disease
☐ Thyroid Disease	☐ Glaucoma	☐ Periodontal Disease	☐ Stroke

Have you taken any of the following: ☐ Denosumab (Prolia) ☐ Alendronate (Fosamax)
☐ Risedronate (Actonel) ☐ Ibandronate (Boniva) ☐ Zoledronic Acid (Reclast)

Do you have any allergies to medications? _____

List any serious illnesses _____

List all surgeries _____

Have you ever had hives or a rash? _____

Do you tend to bleed a long time? _____

Have you had heart trouble? _____

Have you hever had chest pains? _____

Have you ever been exposed to the AIDS virus? _____

Do you have a blood disorder? _____

Have you ever had convulsions or seizures? _____

Do you have artificial joints? _____

Do you smoke? _____ How much? _____

Do you drink alcohol? _____ How much? _____

Do you have any medical problems not mentioned? _____

(Women) Are you pregnant at this time? _____ How long? _____

Please list any drugs/dosages you are taking presently _____

_____

What are your dental concerns? _____

Do you have any of the following? _____

☐ Bleeding gums	☐ Recession	☐ Clenching teeth	☐ Loose teeth	☐ Jaw pain
☐ Tooth shifting	☐ Night grinding	☐ Swelling	☐ Mouth odors	

Comments: _____

_____

_____

As the above information changes it is my responsibility to notify this office.

Patient Signature: _____ Date _____ *Thank you!*

Date Update Initials

_____

_____

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