SMILING 32 DENTAL HOSPITAL

DENTAL IMPLANT patient's medical history:

Patient personal Information:

- Full Name: _____

- Date of Birth: _____

- Contact Number: _____

- Email: _____

Medical History:

1. Are you currently under the care of a physician?

- ☐ Yes

- ☐ No

- If yes, please provide details: _____

2. Do you have any known allergies (e.g., medications, latex, etc.)?

- ☐ Yes

- ☐ No

- If yes, specify: _____

3. Have you ever had any adverse reactions to anaesthesia or medications?*

- ☐ Yes

- ☐ No

- If yes, explain: _____

4. Do you take any medications (prescription, over-the-counter, supplements)?*

- ☐ Yes

- ☐ No

- If yes, list the medications: _____

5. Do you have a history of any of the following conditions (check all that apply):*

- ☐ Heart disease / Heart attack / Stroke

- ☐ High blood pressure

- ☐ Diabetes

- ☐ Bleeding disorders

- ☐ Osteoporosis

- ☐ Respiratory issues (e.g., asthma, COPD)

- ☐ Hepatitis / Liver disease
- ☐ Kidney disease
- ☐ Cancer (currently or previously)
- ☐ HIV/AIDS
- ☐ Epilepsy / Seizures
- ☐ Any other serious conditions: _____

6. Have you ever had any surgeries in the past?*

- ☐ Yes
- ☐ No
- If yes, list the type of surgery and date: _____

7. Do you smoke or use tobacco products?*

- ☐ Yes
- ☐ No
- If yes, how much/how often? _____

8. Do you consume alcohol?*

- ☐ Yes
- ☐ No
- If yes, how much/how often? _____

9. Do you have any issues with healing or clotting?

- ☐ Yes
- ☐ No
- If yes, explain: _____

10. Have you undergone any radiation therapy or chemotherapy?

- ☐ Yes
- ☐ No
- If yes, when and for what condition? _____

Dental History:

1. *Have you had any previous dental surgeries or treatments (e.g., extractions, root canals)?

- ☐ Yes

- ☐ No

- If yes, specify: _____

2. *Do you have a history of gum disease (periodontal disease)?

- ☐ Yes

- ☐ No

- If yes, explain: _____

3. *Do you have any missing teeth (other than the ones for which implants are considered)?

- ☐ Yes

- ☐ No

- If yes, how long have they been missing? _____

4. *Do you have a history of bruxism (teeth grinding or clenching)?

- ☐ Yes

- ☐ No

5. *Do you have any ongoing dental pain or discomfort?

- ☐ Yes

- ☐ No

- If yes, explain: _____

Consent:

I confirm that the above information is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____