ConfiDent
Dental Implant Center

Name _____ **DOB** _____ **Date**_____

Do you have or have you had any of the following conditions?

	YES	NO		YES	NO
Allergies (list below)	____	____	Low Blood Sugar	____	____
Anemia	____	____	Lupus	____	____
Anxiety/Panic Disorder	____	____	Neurological Problems	____	____
Any Immune Diseases	____	____	Organ Transplant	____	____
Arthritis	____	____	Osteoarthritis	____	____
Asthma	____	____	Osteoporosis	____	____
Breathing Problems	____	____	Painful or Replaced Joint	____	____
Cancer	____	____	Persistent Cough	____	____
Chemotherapy	____	____	Psychiatric Care	____	____
Chronic Bronchitis	____	____	Radiation Treatment	____	____
Chronic Fatigue	____	____	Replaced Heart Valves	____	____
Circulatory Problems	____	____	Rheumatic Fever	____	____
Heart Condition	____	____	Sinus Problems	____	____
Diabetes	____	____	Sleep Apnea / Snoring	____	____
Emphysema	____	____	Stroke	____	____
Epilepsy / Seizures	____	____	Teeth Grinding	____	____
Excessive Bleeding	____	____	Thyroid Problems	____	____
Fainting	____	____	Tobacco Use (Any Form)	____	____
Healing Problems	____	____	Tonsillitis	____	____
Hepatitis	____	____	Trauma to Head/Neck	____	____
High / Low Blood Pressure	____	____	Tuberculosis	____	____
History of Tremors	____	____	Ulcers / Gastric Reflux	____	____
History of Tumors	____	____	Use of Alcohol	____	____
HIV-AIDS	____	____	Use of Drugs	____	____
High Cholesterol	____	____	Vascular Graft	____	____
Kidney Disease	____	____	Venereal Disease	____	____
Liver Disease	____	____	Any Other Condition(s) Not Listed (list below)	____	____

Allergies: _____

Other conditions not listed: _____

_____