



Bleeding on probing (%):.....

Grinding disorder? Yes No

Abnormal biting interferences surrounding implant area

(occlusion/articulation):.....  
.....

Interarch and interdental teeth alignment: .....  
.....  
.....

*To be filled out by the patient/guardian of patient if minor.*

Age:

Gender:

Do you have any of the following diseases/conditions?

1. Rheumatoid arthritis Yes No

2. Crohn's disease Yes No

3. Osteoporosis Yes No

4. Diabetes type I Yes No

5. Diabetes type II Yes No

6. Ulcer Yes No

7. Lung disease (e.g. asthma, COPD, emphysema, bronchitis, cystic fibrosis etc)?  
Yes No

If yes, what type of lung disease?.....

8. Heart disease (e.g. angina, hypertension, hypotension, myocardial infarction, heart attack etc)?  
Yes No

If yes, what type of heart disease?.....

9. Hormonal disorder Yes No

If yes, what type of hormonal disorder?.....

10. Blood disease Yes No

If yes, what type of blood disease?.....

11. Cancer Yes No

If yes, what type of cancer and what treatment did you receive?.....  
.....

12. Psychological disorder (depression, anxiety, schizophrenia etc)? Yes No

If yes, what type of psychological disorder?.....

13. Xerostomia (dry mouth) Yes No

14. Hyposalivation Yes No

If yes, what is the reason behind your hyposalivation?.....

15. Stress Yes No

16. Do you take any medications regularly? Yes No

If yes, please specify which ones?

.....  
.....  
.....

17. Do you smoke cigarettes/pipe/cigars regularly? Yes No

If yes, how many cigarettes/pipe/cigars do you smoke daily?.....

18. Do you snuff regularly? Yes No

If yes, how much and how often?.....

19. Have you quit smoking/snuffing, if yes when and for how long?

.....

20. Do you drink alcohol? Yes No

21. If yes, how many pints a week?.....

22. Do you have or have you had a drinking problem?.....