

Current Medical History 2026

Patient Name:

Birth Date:

Date Created:

This information is vital to allow us to provide appropriate care for you. We do not use this information to discriminate.

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Have you had an orthopedic total joint (hip,knee,elbow,finger) replacement? Yes No If yes

Are you taking any medications? Yes No If yes

Have you ever taken alendronate or risendronate (Fosomax/Actonel) for osteoporosis? Yes No If yes

Have you had intravenous bisphosphonates? Yes No

Have you had previous infective endocarditis, damaged heart valve or artificial heart valve? Yes No

Do you have congestive heart failure, cardiovascular disease or congenital heart disease? Yes No

Do you have neurological, gastrointestinal or autoimmune disease? Yes No

Are you pregnant or nursing? Yes No

Do you use tobacco? Yes No

Have you had any periodontal (gum) treatments? Yes No

Do you have pain, clicking or popping in jaw joints? Yes No

Have you been diagnosed or have signs of...

ADD/ADHD Alzheimer's Anxiety Autism Spectrum Disorder

Dementia Depression Excessive Worry OCD

Sensory Disorder

Other? Yes No If yes

Are you allergic to the following?

Acrylic Aspirin Latex Local Anesthetics

Metal Penicillin Sulfa Drugs

Other? Yes No If yes

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

Acid Reflux/GERD	<input type="radio"/> Yes <input type="radio"/> No	AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Angina	<input type="radio"/> Yes <input type="radio"/> No	Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Asthma	<input type="radio"/> Yes <input type="radio"/> No
Bleeding Disorder	<input type="radio"/> Yes <input type="radio"/> No	Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No	Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No
Chronic Pain	<input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medication	<input type="radio"/> Yes <input type="radio"/> No	Diabetes I or II	<input type="radio"/> Yes <input type="radio"/> No
Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Eating Disorder	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No
Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No
Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A, B, or C	<input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No
Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Mitro Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Sleep Disorder	<input type="radio"/> Yes <input type="radio"/> No	STD	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? Yes No If yes

Cosmetic Evaluation

Are you happy with your smile? Yes No

Comments

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient, Parent or Guardian:

X

Date: _____