T. LANCE COLLIER, DMD, LLC

Family Practice *of* General Dentistry

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your overall health status is very important to developing a safe and effective treatment plan that suits your dental needs. Health problems and medications can affect the course of dental treatment you receive. Please answer the following questions honestly.

NAME: _____ **DATE**: _____

Are you currently under the care of a physician? □YES □NO What was the date of your last physical exam? _____

Physician's name: _____ Physician's phone#: _____

Please list any medications or dietary supplements that you are currently taking:

_____

_____

_____

Have you ever been hospitalized or had a major operation?	☐YES	☐NO	Explain: _____
Do you take, or have you taken, Phen-Fen, Redux, or other diet pills?	☐YES	☐NO	Explain: _____
Are you on a special diet?	☐YES	☐NO	Explain: _____
Do you smoke or use tobacco?	☐YES	☐NO	How much? _____packs/day or dip_____
Do you use controlled substances?	☐YES	☐NO	Explain: _____
Do you take anticoagulants/blood thinners? (including daily aspirin)	☐YES	☐NO	Explain: _____
Have you ever had excessive bleeding requiring special treatment?	☐YES	☐NO	Explain: _____
Have you ever had a joint replacement?	☐YES	☐NO	Explain: _____

Do you have an ALLERGY to any of the following:

□Aspirin □Penicillin □Latex □Codeine/Other Narcotic □Sulfa □Dental Anesthetics/Novacaine

□Acrylic □Metal □Other: _____

FOR WOMEN

Are you pregnant? ☐YES ☐NO Due date:_____ Name of Obstetrician: _____

Are you attempting to become pregnant? ☐YES ☐NO Obstetrician's phone#: _____

Are you breastfeeding or nursing? ☐YES ☐NO Are you taking birth control pills? ☐YES ☐NO

Due to new medical research involving the dental impact of medications used for the treatment of osteoporosis and in some cancer therapies, it is important that we know if you have taken any of the following drugs:

Oral Medications:	IV Medications	
☐**Actonel**	☐ **Aredia**	If so, how long have you been taking this medication: _____
☐**Boniva**	☐ **Bonefos**	If you no longer take the medication, how long did you take the medication and when
☐**Fosamax**	☐ **Boniva IV**	did you stop using it? _____
☐**Fosamax plus D**	☐ **Reclast**	*For IV medications:*
☐**Skelid**	☐ **Zometa**	When were you last administered the medication? _____
☐**Didrone**		Will you be treated with this again in the future? _____

T. LANCE COLLIER, DMD, LLC

Family Practice *of* General Dentistry

MEDICAL HISTORY, Continued

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

Recent illness-past year ☐YES ☐NO	Pneumonia ☐YES ☐NO	Frequent headaches ☐YES ☐NO
Recent cough or cold ☐YES ☐NO	Anemia/Low iron ☐YES ☐NO	Convulsions ☐YES ☐NO
Heart trouble ☐YES ☐NO	Sickle Cell Disease ☐YES ☐NO	Epilepsy/Seizures ☐YES ☐NO
Irregular heart beat ☐YES ☐NO	Hemophilia ☐YES ☐NO	Cerebral Palsy ☐YES ☐NO
Arrhythmia ☐YES ☐NO	Scarlet fever ☐YES ☐NO	Psychiatric treatment ☐YES ☐NO
Heart Attack/MI ☐YES ☐NO	Bruise easily ☐YES ☐NO	Alzheimer's Disease ☐YES ☐NO
Angina/Chest pain ☐YES ☐NO	Stomach ulcers ☐YES ☐NO	Cancer ☐YES ☐NO
Heart murmur ☐YES ☐NO	Intestinal Disease ☐YES ☐NO	Chemotherapy ☐YES ☐NO
Congenital heart defect ☐YES ☐NO	Frequent diarrhea ☐YES ☐NO	Radiation treatment ☐YES ☐NO
Rheumatic fever ☐YES ☐NO	Gastric Bypass ☐YES ☐NO	Tumors or Growths ☐YES ☐NO
Mitral valve prolapse ☐YES ☐NO	Acid reflux/GERD ☐YES ☐NO	Leukemia ☐YES ☐NO
Prosthetic heart valve ☐YES ☐NO	Blood transfusion ☐YES ☐NO	Recent weight loss ☐YES ☐NO
Pacemaker/Defibrillator ☐YES ☐NO	AIDS/HIV positive ☐YES ☐NO	Arthritis/Gout ☐YES ☐NO
High blood pressure ☐YES ☐NO	Hepatitis A ☐YES ☐NO	Swelling of joints ☐YES ☐NO
Low blood pressure ☐YES ☐NO	Hepatitis B or C ☐YES ☐NO	Rheumatism ☐YES ☐NO
Lung disease ☐YES ☐NO	Tuberculosis ☐YES ☐NO	Yellow jaundice ☐YES ☐NO
Congestive heart failure ☐YES ☐NO	Cold sores/Fever blisters ☐YES ☐NO	Liver Disease ☐YES ☐NO
Shortness of breath ☐YES ☐NO	Herpes ☐YES ☐NO	Kidney Disease ☐YES ☐NO
Asthma ☐YES ☐NO	Shingles ☐YES ☐NO	Renal dialysis ☐YES ☐NO
Anaphylaxis ☐YES ☐NO	Venereal Disease ☐YES ☐NO	Thyroid Disease ☐YES ☐NO
Hay fever ☐YES ☐NO	Hives or rash ☐YES ☐NO	Parathyroid Disease ☐YES ☐NO
Sinus trouble ☐YES ☐NO	Hypoglycemia ☐YES ☐NO	Cortisone or ACTH ☐YES ☐NO
COPD/Emphysema ☐YES ☐NO	Diabetes ☐YES ☐NO	Glaucoma ☐YES ☐NO
Bronchitis ☐YES ☐NO	Excessive thirst ☐YES ☐NO	Contact Lenses ☐YES ☐NO
Tonsillitis ☐YES ☐NO	Stroke/CVA ☐YES ☐NO	Drug Addiction ☐YES ☐NO
Chronic cough ☐YES ☐NO	Fainting spells/Dizziness ☐YES ☐NO	

Additional comments: _____

_____

_____

_____

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need in the normal course of diagnosis and treatment. I understand that I am financially responsible for all charges.

Signature: _____ Date: _____