Colliver Dental Group, P.A.

Date 1/26/2021

Medical History Form

Patient Name: Birth Date: Date Created:

Your mouth is a part of your entire body. So, health problems that you may have, or medication that you may be taking, could have an important relationship with the dental treatment you receive

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
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	If yes
Do you use tobacco? (including vaping)	◯ Yes ◯ No	If yes
Do you use medical cannabis?	◯ Yes ◯ No	If yes
Do you use any controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Acrylic ☐ Aspirin ☐ Codiene ☐ Latex

☐ Local Anesthetic ☐ Metal ☐ Penicillin ☐ Sulfa

OTHER ALLERGIES: ☐ If yes

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

ADD/ADHD	◯ Yes ◯ No	AIDS/HIV	◯ Yes ◯ No	Acid Reflux	◯ Yes ◯ No	Alzheimers Disease	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Anxiety/Depression	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Atrial Fibrillation	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Cancer	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Chest Pain/Angina	◯ Yes ◯ No	Cold Sores	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No
Cortisone Medication	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No
Epilepsy/Seizures	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Fainting Spells	◯ Yes ◯ No
Frequent Cough	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No
Hay Fever	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Heart Murmer	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No
Heart Trouble/Disease	◯ Yes ◯ No	Hepatitis A, B, or C	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
High Cholesterol	◯ Yes ◯ No	Hives/Rash	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No
Lung Disease	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Obstructive Sleep Apnea	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Other Dementia	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Parkinson's Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No
Radiation Treatment	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Renal Disease	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Sickle Cell Disease	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Swelling of Limbs	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No

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

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____