Thomas P. Collins, D.D.S.
Time-honored patient care…
State of the art dentistry.

MEDICAL HISTORY FORM

Patient Name		
Physician:	Physician phone number:	
Have you been under the active care of a physician for an ongoing issue over the past two years? If yes, please describe:		Y N
Are you currently taking any medications, drugs, pills, herbal remedies, including aspirin? If yes, please list.		Y N
Have you taken prescription medications for weight loss, such as Fen-Phen, Pondimen, or Redux?		Y N
Have you taken prescription medications for bone density such as Fosamax, Actonel, or Boniva?		Y N
Have you ever had an adverse or allergic reaction of any medications? If so, please list.		Y N
Have you been admitted to the hospital in the last 5 years? For:		Y N
Have you had or currently have any of the following:		

Cardiology:			**Endocrine:**			**Immunologic:**		
Heart Condition	Y	N	Liver disease/Yellow Jaundice	Y	N	Cold sores/fever blisters	Y	N
Chest Pain	Y	N	Thyroid Problems	Y	N	Blood Transfusion	Y	N
Heart Murmur	Y	N	Glaucoma	Y	N	Hay Fever/Allergy/Hives	Y	N
High/Low Blood Pressure	Y	N	**Respiratory:**			Latex sensitivity	Y	N
Mitral Valve Prolapse	Y	N	COPD/Emphysema	Y	N	**Neurologic**:		
Artificial Heart Valve/Pacemaker	Y	N	Chronic Cough	Y	N	Neurological Disorders	Y	N
Stroke	Y	N	Tuberculosis	Y	N	Epilepsy or Dizzy spells	Y	N
Swollen Ankles/Bruise Easily	Y	N	Asthma	Y	N	Nervous/Anxious	Y	N
Rheumatic Fever	Y	N	Sinus Trouble	Y	N	Psychiatric/Psychological Care	Y	N
Hemophilia/Sickle Cell	Y	N						
Musculoskeletal:						**Neoplastic**:		
Arthritis/Rheumatism	Y	N	**Acquired Diseases**:			Tumors / cancer	Y	N
Artificial Joints	Y	N	Hepatitis A, B or C	Y	N	Radiation/Chemotherapy	Y	N
Gastro-urologic:			Venereal Disease	Y	N			
Kidney Trouble	Y	N	HIV/AIDS	Y	N	**Other:**		
Ulcers	Y	N				Diet (special or restricted)	Y	N
Diabetes	Y	N				Contact Lenses	Y	N

Have you had any diseases or conditions not listed above? Yes No if yes, what?____
Have you gained or lost more than 10 pounds in the past year? Yes No if yes which?____
Women: Are you pregnant or think you could be pregnant? Yes No if yes how far along?____________________________________
Women: Are you nursing Yes No Women: Are you using birth control prescriptions? Yes No
Anything else you would like to share?

I understand the above information is necessary to provide me with dental care in a safe and caring manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency. I will notify the doctor or any change in my health or medication.

______________________________ ______________________________
Patient Signature Date

Doctor's Notes: ____

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______________________________ ______________________________
Doctor's signature Date

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