CompleteDentalHealth
YOUR SMILE IS OUR REWARD
619.295.2202 • www.completedentalhealth.com

Timothy N. Collins, D.D.S.

Accurate answers will help us provide you the safest treatment experience. All information you provide is confidential.
If you need assistance or have a question, please ask.

Patient's Name _____ _____
Last First Middle Today's Date

PATIENT MEDICAL HISTORY

Date of Birth ____/____/____ Date of last physical exam ____/____/____

Your PHYSICIAN'S name and phone # _____

Yes ❑ No ❑ Have you ever been hospitalized or had surgery?

If yes, please give year and reasons or types of operations. _____

_____

Yes ❑ No ❑ **Latex sensitivity**

Please mark YES or NO and CIRCLE any specific condition you currently have or have had previously.

MEDICATIONS

Have you ever taken any of the following:

Yes ❑ No ❑ cortisone, steroids
Yes ❑ No ❑ heparin, coumadin, blood thinners, anticoagulants
Yes ❑ No ❑ antidepressants, sedatives, psychiatric medicine
Yes ❑ No ❑ heart or blood pressure medications
Yes ❑ No ❑ nitroglycerin
Yes ❑ No ❑ Fen-Phen, Pondimen, Redux

Please list all prescription and over-the-counter medications you are currently taking _____

_____

_____

_____

Yes ❑ No ❑ Any change in your general health in the last year?
Yes ❑ No ❑ weight change greater than 10 pounds in the last year
Yes ❑ No ❑ do you exercise regularly
Yes ❑ No ❑ mitral valve prolapse, heart murmur
Yes ❑ No ❑ congenital heart defects, artificial valves, endocarditis
Yes ❑ No ❑ angina, chest pain
Yes ❑ No ❑ heart attack, heart disease
Yes ❑ No ❑ pacemaker, irregular heart beat
Yes ❑ No ❑ heart surgery
Yes ❑ No ❑ high blood pressure
Yes ❑ No ❑ stroke, embolus, thrombosis
Yes ❑ No ❑ swollen ankles
Yes ❑ No ❑ difficulty breathing at night, snoring, sleep apnea
Yes ❑ No ❑ asthma, hayfever
Yes ❑ No ❑ tuberculosis, T.B.
Yes ❑ No ❑ emphysema, pneumonia
Yes ❑ No ❑ persistent cough, bronchitis
Yes ❑ No ❑ seizure disorder, epilepsy, convulsion
Yes ❑ No ❑ severe headaches, migraines
Yes ❑ No ❑ fainting, dizziness
Yes ❑ No ❑ eating disorder, anorexia, bulimia
Yes ❑ No ❑ depression, psychosis, schizophrenia
Yes ❑ No ❑ psychiatric care, counseling
Yes ❑ No ❑ neurological or neuromuscular disorder
Yes ❑ No ❑ ulcer or stomach problem
Yes ❑ No ❑ chronic diarrhea, intestinal problem
Yes ❑ No ❑ kidney or bladder problem
Yes ❑ No ❑ sexually transmitted disease
Yes ❑ No ❑ hepatitis, cirrhosis, liver disease
Yes ❑ No ❑ eye problems or disease
Yes ❑ No ❑ sinus problems or infection
Yes ❑ No ❑ ear problems or infection
Yes ❑ No ❑ diabetes or high blood sugar
Yes ❑ No ❑ swollen glands or lymph nodes
Yes ❑ No ❑ been tested for HIV
Yes ❑ No ❑ HIV+, ARC, AIDS
Yes ❑ No ❑ bleeding problem, hemophilia
Yes ❑ No ❑ bruise easily, slow healing
Yes ❑ No ❑ blood disorder, blood transfusion, sickle cell
Yes ❑ No ❑ artificial joints
Yes ❑ No ❑ arthritis, joint pain, back problems
Yes ❑ No ❑ skin problem or disease
Yes ❑ No ❑ cancer or tumor
Yes ❑ No ❑ radiation treatment, chemotherapy
Yes ❑ No ❑ past or present drug use including cocaine, crack, methamphetamine, etc.
Yes ❑ No ❑ do you smoke? # of packs per day _____ for how long? _____
Yes ❑ No ❑ chewing tobacco or snuff
Yes ❑ No ❑ do you drink alcohol? # of drinks per week _____
Yes ❑ No ❑ do you participate in any sports _____

_____

— please continue on opposite side —

ALLERGIES

Do you have any of the following allergies:

Yes ❑ No ❑ Penicillin, sulfa, any antibiotic
Yes ❑ No ❑ local anesthetics (novocaine, lidocaine, etc.)
Yes ❑ No ❑ aspirin, codeine, or other pain medication
Yes ❑ No ❑ hives, contact dermatitis, latex sensitivity
Yes ❑ No ❑ allergic to any other medication _____

Yes ❑ No ❑ Do you have any disease, condition or problem not listed above? _____
_____

WOMEN ONLY

Yes ❑ No ❑ are you pregnant or possibly pregnant
Yes ❑ No ❑ are you nursing
Yes ❑ No ❑ are you taking birth control pills

DENTAL HISTORY

Yes ❑ No ❑ tooth or mouth pain recently
Yes ❑ No ❑ how nervous does dental treatment make you:
_____ not at all _____ slightly
_____ moderately _____ extremely
Yes ❑ No ❑ any awareness of clenching or grinding your teeth
Yes ❑ No ❑ jaw clicking, popping, or grinding
Yes ❑ No ❑ jaw or TMJ pain
Yes ❑ No ❑ ever worn partials or dentures
Yes ❑ No ❑ orthodontic treatment / braces
Yes ❑ No ❑ ulcers / sores in mouth or on lips
Yes ❑ No ❑ unpleasant taste / bad breath
Yes ❑ No ❑ swelling, lumps, bumps in mouth
Yes ❑ No ❑ periodontal / gum surgery or disease
Yes ❑ No ❑ oral surgery
Yes ❑ No ❑ any unpleasant experience with dental treatment. If yes, describe _____
_____

Yes ❑ No ❑ any complication with / reaction to past dental treatment
Yes ❑ No ❑ any injury to your teeth, mouth, jaws, or head

Reason for today's visit _____
_____

How do you feel about the appearance of your front teeth
_____
_____

Yes ❑ No ❑ do you have any other dental concerns
_____

Previous dentists name _____
City _____
Date of last dental treatment _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be very dangerous to my health. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest time, and I agree to do so.

Signature | Date | Relationship to patient if other than self

AUTHORIZATION FOR USE OF IMAGE AND BIOGRAPHICAL INFORMATION

I am a patient of Dr. _____ . I understand that my dentist may take video or still images of the work that he is doing. I consent to my dentist, or a representative of his staff, taking these images. I understand that my dentist may use my images, and biographical information that I provide to my dentist, for purposes of education, publicity, promotion and advertising. I understand that I will receive no remuneration for such use.

Signature | Date