Shwedel Dental

FAMILY, COSMETIC & LASER DENTISTRY

25650 Goddard Rd., Suite A, Taylor, MI 48180

PATIENT NAME _____ REG# _____

Email address _____ Date of birth _____

HEALTH HISTORY FORM

Please (CIRCLE) the appropriate response next to each question below: Yes (Y), No (N), Don't Know (?)

MEDICAL HISTORY

Do you have or have you had any of the following:

1. Breathing problems?

a. Asthma	Y	N	?
b. Emphysema	Y	N	?
c. Bronchitis	Y	N	?
d. Tuberculosis	Y	N	?
e. Shortness of breath	Y	N	?
f. Other breathing problems	Y	N	?

Explain: _____

2. Heart or circulation problems?

a. High blood pressure	Y	N	?
b. Heart attack	Y	N	?
c. Angina or chest pain	Y	N	?
d. Irregular heart beat	Y	N	?
e. Rheumatic fever	Y	N	?
f. Heart murmur	Y	N	?
g. Mitral valve prolapse	Y	N	?
h. Damage to heart valves	Y	N	?
i. Heart valve replacement	Y	N	?
j. Pacemaker/other cardiac device	Y	N	?
k. Congestive heart failure	Y	N	?
l. Swollen ankles	Y	N	?
m. Other heart or circulation problems	Y	N	?

Explain: _____

3. Kidney or urinary problems?

a. Kidney disease	Y	N	?
b. Dialysis	Y	N	?
c. Frequent urination	Y	N	?
d. Other kidney problems	Y	N	?

Explain: _____

4. Nervous system problems?

a. Stroke or transitory ischemic attack	Y	N	?
b. Fainting spells	Y	N	?
c. Convulsions, seizures or epilepsy	Y	N	?
d. Other nervous system problems	Y	N	?

Explain: _____

5. Head and neck problems?

a. Nose or sinus problems	Y	N	?
b. Swollen Glands	Y	N	?
c. Oral cancer	Y	N	?
d. Impairment of hearing, sight or speech	Y	N	?
e. Frequent or severe headaches	Y	N	?
f. Other head and neck problems	Y	N	?

Explain: _____

6. Hormone or gland problems?

a. Thyroid disease (hypothyroidism, hyperthyroidism)	Y	N	?
b. Diabetes	Y	N	?
c. Adrenal or pancreatic disease	Y	N	?
d. Any other hormone/gland disease	Y	N	?

Explain: _____

7. Muscle, bone or skin problems?

a. Arthitis	Y	N	?
b. Osteoporosis	Y	N	?
c. Artificial joint placement	Y	N	?
d. Hives or skin rash	Y	N	?
e. Skin cancer	Y	N	?
f. Back problems	Y	N	?
g. Other muscle, bone or skin disease	Y	N	?

Explain: _____

8. Stomach, liver or intestinal problems?

a. Liver disease	Y	N	?
b. Hepatitis	Y	N	?
c. Acid reflux (GERD)	Y	N	?
d. Ulcers	Y	N	?
e. Other stomach, intestinal or liver problems	Y	N	?

Explain: _____

9. Behavioral/Sensory disorders or Autism? Y N ?

Explain: _____

EXAMINER'S COMMENTS _____

_____

_____

_____

over please

FORM SFS-003 REV. 12/17 TRENTON PRINTING, INC. 734-675-3255

10. Allergic reactions or other problems?

a. Seasonal allergies Y N ?

b. Allergy, reaction or intolerance to:

Penicillin Y N ?

Erythromycin Y N ?

Codeine Y N ?

Latex Y N ?

Local anesthetics Y N ?

Foods/flavoring Y N ?

Other substances Y N ?

Explain: _____

_____

11. Blood or immune system problems?

a. Cancer of any type Y N ?

b. Organ or bone marrow transplant Y N ?

c. Lupus Y N ?

d. Multiple sclerosis Y N ?

e. Anemia Y N ?

f. Hemophilia Y N ?

g. AIDS/HIV Y N ?

h. Frequent nosebleeds, increased bruising or bleeding Y N ?

i. Are you taking any blood thinners? Y N ?

j. Have you had chemotherapy or radiation treatment? Y N ?

k. Other problems with the blood or immune system? Y N ?

Explain: _____

12. What medications or other substances are you taking or have you taken in the past 2 months?

a. Please list all prescription and non-prescription drugs including aspirin, birth control pills, herbal medications or other supplements. Write "none" if you are not taking any medications or other substances.

_____

_____

_____

_____

b. Have you ever taken the drugs Fenfluramine (Fen-phen), Pondimin, or Dexfenfluramine (Redux)? Y N ?

c. Have you taken or are you taking drugs to control bone loss (ie. Fosamax) Y N ?

13. Personal History

a. Have you ever been hospitalized, had major surgery or been seriously hurt? Y N ?

If yes, what type and when _____

b. Have you had or do you have any sexually transmitted diseases (syphilis, gonorrhea, herpes, etc.)? Y N ?

c. Do you need any special accommodations for dental treatment? Y N ?

d. Are you pregnant? Y N ?

e. Have you ever used tobacco products? Y N ?

f. Are you currently using tobacco products? Y N ?

What type and how often _____

g. How many alcohol containing drinks do you consume a week? _____

h. Do you use or have you used any recreational drugs? Y N ?

i. Have you ever had a problem with alcohol or drugs? Y N ?

j. Do you have mental health problems? Y N ?

k. When was your last visit to a physician (medical doctor)? _____

l. Do you have a physician (medical doctor)? Y N ?

If yes, please provide the Name, Address and Telephone _____

_____

EXAMINER'S COMMENTS _____

_____

_____

_____

DENTAL HISTORY

1. What is the reason for your dental visit? _____

   _____

2. Have you ever had any problems following dental treatment? Y N ?
   If yes, explain _____
3. Have you ever had a bad or unusual reaction to local anesthetic? Y N ?
4. Have you ever had a severe injury to your face, teeth or jaws? Y N ?
5. Have you ever had surgery in your mouth or on your lips? Y N ?
6. Have you ever had periodontal treatment to your gums? Y N ?
7. Have you ever had orthodontic treatment to straighten your teeth? Y N ?
8. Have you ever had extraction (pulling) of any teeth? Y N ?
9. Have you ever had endodontics (root canals) on any teeth? Y N ?
10. Have you had any teeth replaced by a removable denture, fixed bridge or implant? Y N ?
11. Have you ever worn a bitesplint/nightguard? Y N ?
12. Have you had a recent toothache? Y N ?
13. Are your teeth sensitive to hot, cold or pressure? Y N ?
14. Do you have bleeding gums? Y N ?
15. Do you have trouble chewing? Y N ?
16. Do you clench or grind your teeth? Y N ?
17. Do you have difficulty opening your mouth as wide as you would like? Y N ?
18. Do your jaw joints or muscles hurt? Y N ?
19. Does your jaw click, pop, or lock when you chew? Y N ?
20. Do you experience dry mouth? Y N ?
21. Do you have sores in or around your mouth? Y N ?
22. Please circle the amount of sugar in your diet. small moderate high
23. When was the last time your teeth were cleaned at a dental office? _____
24. How often do you brush? _____
25. How often do you use dental floss? _____
26. Are you satisfied with the appearance of your teeth? Y N ?
    If No, Why not? _____
27. What would keep you from continuing with necessary dental treatment? (please circle)
    Fear Time Urgency Budget No Trust
28. What do you value most in regards to dental treatment? (please circle)
    Cosmetic Function Comfort Longevity

EXAMINERS COMMENTS _____

_____

_____

_____

over please

I certify that to the best of my knowledge the above information is complete and accurate.

Patient signature_____ Date _____

If other than the patient, indicate relationship _____

Reviewed by Dr. _____

1st Review and update of questionaire:

Changes _____

_____

Patient signature_____ Date _____

If other than patient, indicate relationship _____

Update reviewed by Dr._____

2nd Review and update of questionaire:

Changes _____

_____

Patient signature_____ Date _____

If other than patient, indicate relationship _____

Update reviewed by Dr._____

3rd Review and update of questionaire:

Changes _____

_____

Patient signature_____ Date _____

If other than patient, indicate relationship _____

Update reviewed by Dr._____

The health history form should be updated at least every 6 months and a new form must be filled out every 2 years.