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And Associates

FAMILY & COSMETIC DENTISTRY

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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. Arthritis | 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: _____

EXAMINER'S COMMENTS _____

9. 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: _____

10. 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: _____

11. 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 ?

12. 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 recreational drugs? Y N ?
- i. Have you ever had a problem with alcohol and/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, please 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 missing teeth replaced by a removable denture, fixed bridge or an 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 a 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. Do you have any questions, concerns, or additional information you would like us to know before we treat you? Y N ?
If Yes, please specify? _____

28. How do you feel about going to the dentist (please circle) Scared Apprehensive No problem

EXAMINER'S COMMENTS _____

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

Patient signature _____ Date _____

If other than the patient, indicated relationship _____

Reviewed by Dr. _____

Review and update of questionnaire:

Patient signature _____ Date _____

If other than the patient, indicated relationship _____

Changes _____

Update reviewed by Dr. _____

Review and update of questionnaire:

Patient signature _____ Date _____

If other than the patient, indicated relationship _____

Changes _____

Update reviewed by Dr. _____

Review and update of questionnaire:

Patient signature _____ Date _____

If other than the patient, indicated relationship _____

Changes _____

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.