PATIENT NAME Sharon REG# 111999

Date of birth 9-26-64

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: sometimes swollen glands

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: all joints ache

Psoriasis, had basal cell removed

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 _____

over please

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: 2-hydroxy-methyl methacrylate dental cement?

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: might have lupus, being worked up for this.

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.

Multivitamins, Calcium

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 D+C, uterine ablation, 10 years ago, appendix, tonsils in teens

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? 6

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)? last month

l. Do you have a physician (medical doctor)? (Y) N ?
If yes, please provide the Name, Address and Telephone Dr. Anderson, Ann Arbor

EXAMINER'S COMMENTS _____

DENTAL HISTORY

1. What is the reason for your dental visit? Sore, bleeding, red gums

2. Have you ever had any problems following dental treatment? (Y) N ?
   If yes, please explain Upper front gums are red after veneers placed
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? 2 mos. ago
24. How often do you brush? 2-4 a day
25. How often do you use dental floss? 2-4 a day
26. Are you satisfied with the appearance of your teeth? Y (N) ?
    If No, Why not? Red gums
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 _____

over please

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

Patient signature _____ Date _____

Examiner _____ Date _____

Checked by _____ Date _____

Review and update of questionnaire:

Patient signature _____ Date _____

Examiner _____ Date _____

Checked by _____ Date _____

Review and update of questionnaire:

Patient signature _____ Date _____

Examiner _____ Date _____

Checked by _____ Date _____

Review and update of questionnaire:

Patient signature _____ Date _____

Examiner _____ Date _____

Checked by _____ Date _____

Review and update of questionnaire:

Patient signature _____ Date _____

Examiner _____ Date _____

Checked by _____ Date _____

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

updated 7/06 by cj