SCHOOL OF DENTISTRY
UNIVERSITY OF MICHIGAN

PATIENT NAME _____ 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: _____



*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: _____

_____

### 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 _____

_____

# 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 |

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

Patient signature _____ Date _____

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## Patient Registration Information – Please Print using black or blue ink

| Title | Patient's Last Name | First Name | Middle | Preferred | Gender |
|---|---|---|---|---|---|
| | | | | | |

| Date of Birth | Social Security No. | Marital Status | Email Address |
|---|---|---|---|
| | | | |

| Home Address | Apt or Box No. | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |

Home Phone Number | Daytime Phone Number | Cell Phone Number | Preferred Contact Number

Emergency Contact – Name | Relation | Daytime Phone No. | Address (Street, City, State, Zip)

Race/Ethnicity (optional)
Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐

Hispanic / Latin / Spanish Yes ☐ No ☐

## Guardian Information

| Title | Last Name | First Name | Middle | Relation | Gender |
|---|---|---|---|---|---|
| | | | | | |

| Date of Birth | Social Security No. | Marital Status | | |
|---|---|---|---|---|
| | | | | |

| Home Address | Apt or Box No. | City | State | Zip Code | Email Address |
|---|---|---|---|---|---|
| | | | | | |

Home Phone Number | Daytime Phone Number | Cell Phone Number | Preferred Contact Number

## Patient's Primary Dental Insurance Information

| Subscriber's Name | Subscriber's ID | Subscriber's DOB | Insurance Co. | Group No. |
|---|---|---|---|---|
| | | | | |

| Employer | Address of Employer | Subscriber's Relationship to Patient |
|---|---|---|
| | | |

## Patient's Secondary Dental Insurance Information

| Subscriber's Name | Subscriber's ID | Subscriber's DOB | Insurance Co. | Group No. |
|---|---|---|---|---|
| | | | | |

| Employer | Address of Employer | Subscriber's Relationship to Patient |
|---|---|---|
| | | |

**Assignment of Benefits and Release of Information**

I authorize the University of Michigan School of Dentistry (UMSD) or the Dental Faculty Associates (DFA) to release any and all information contained in my dental/ medical records to (a) any third party payer, insurance agencies or carriers or their agents which may be responsible in whole or in part for paying any expenses associated with my treatment; (b) any health care facility or provider for the purpose of facilitation continuing care and treatment; (c) attorneys or agencies representing the UMSD or the DFA in connection with collection actions against insurers, benefit plan, or the patient, or estate; and (d) any federal or state agency as required by law.

I assign and authorize direct payment of all health care benefits and other forms of payment of any kind which relate to the care provided to me at the UMSD, the DFA or its offsite clinics for application to my bill(s). I assign to the UMSD or the DFA all claims benefits or any related rights or claims I may have under the Employment Retirement Income Security Act (ERISA) or other applicable law, against any insurer, employee, trustee, fiduciary, employee welfare plan, employee benefit association, or other person who may be liable to pay charges due to the UMSD or the DFA for my care, and agree that the UMSD or the DFA may pursue any claim to these benefits, whether or not I choose to pursue that claim. I guarantee full financial responsibility for payment of all expenses associated with my care and treatment, including any portion of any charges not paid by insurance, including motor vehicle insurance, worker's compensation or social agencies and agree to pay the same at the time of delivery of service, discharge from treatment, or on any interim basis. These expenses will include but are not limited to deductibles, co-insurance, non-covered benefits services, and services requiring prior authorization which were not authorized

**Signature of Patient, Parent, or Guardian** _____ Date _____ **Relationship to Patient** _____

**Witness Signature** _____ Date _____

Revised 8/2014