



Michigan Center
For Advanced Dentistry
"An Evolution in Healthcare"

Health History

Please check if you have or have experienced any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cortisone | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Treatments | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Artificial Heart | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral Valve | <input type="checkbox"/> Surgical implant |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Prolapse | <input type="checkbox"/> Swelling in ankles |
| <input type="checkbox"/> Atopic | <input type="checkbox"/> Food Allergy | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Weight gain/ loss | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Dependency | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic fever | |

List any medications: _____

List any drug allergies: _____

Do you have any specific concerns with your teeth today? Any pain? Explain: _____

Former Dentist: _____ Phone: _____ City: _____

Approximate date of last Dental Cleaning _____ X-rays: _____

How often do you brush? _____ Do you like the appearance of your teeth? _____

Have you ever experience an adverse reaction in conjunction with a dental procedure? _____

Are you currently taking Boniva or Fosamax? _____

Please check if you have or have had:

- | | |
|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Loose teeth or broken fillings |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Periodontal Treatment |
| <input type="checkbox"/> Clicking or popping jaws | <input type="checkbox"/> Sensitivity to cold/hot/sweet |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Discomfort when biting |
| <input type="checkbox"/> Grinding or clenching | <input type="checkbox"/> Sores in mouth |

I have reviewed the information and it is accurate to the best of my knowledge. I understand this information will be used by the dentist to help determine appropriate dental treatment. If there is any change with my medical status, I will inform the dentist.

Signature: _____ Date: _____