Dr. E. Kent Shirley
HEALTH HISTORY FORM

Patient Name _____ Birth Date _____ Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you in good health? ❍ **Yes** ❍ **No**

Has there been any change in your general health within the past year? ❍ **Yes** ❍ **No**

If yes:

Date of your most recent physical exam.

Are you currently under the care of a physician? If so, what is the illness or difficulty? ❍ **Yes** ❍ **No**

If yes:

Have you had any serious illness, operations or been hospitalized in the past 5 years? ❍ **Yes** ❍ **No**

If yes:

Have you ever had a serious head or neck injury? ❍ **Yes** ❍ **No**

Are you taking any medications including non-prescription? If so, please list. ❍ **Yes** ❍ **No**

If yes:

Do you have any disease, condition or troubles not listed above? If so, explain. ❍ **Yes** ❍ **No**

If yes:

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❍ **Yes** ❍ **No**

Do you require a pre-medication before any dental treatment? ❍ **Yes** ❍ **No**

Have you had any serious trouble associated with any previous dental treatment? If so, explain. ❍ **Yes** ❍ **No**

If yes:

Do you use tobacco? ❍ **Yes** ❍ **No**

Are you wearing removable dental appliances? ❍ **Yes** ❍ **No**

Do you have any sores or lumps in your mouth? ❍ **Yes** ❍ **No**

Have you had any periodontal treatment? (pyorrhea) ❍ **Yes** ❍ **No**

Are your teeth tender to chew on? ❍ **Yes** ❍ **No**

Have you had any facial swelling or sores within the last year? ❍ **Yes** ❍ **No**

Do you find that your jaw clicks or locks at times? ❍ **Yes** ❍ **No**

Do you have or have you had any of the following diseases or difficulties?

a) Damaged or artificial heart valves? ❍ **Yes** ❍ **No**

b) Cardiovascular disease (heart trouble, heart attack, angina, coronary occlusion, high blood pressure)? ❍ **Yes** ❍ **No**

1) Do you have chest pain upon exertion? ❍ **Yes** ❍ **No**

2) Are you ever short of breath after mild exercise? ❍ **Yes** ❍ **No**

3) Do your ankles swell? ❍ **Yes** ❍ **No**

4) Do you have inborn heart defects? ❍ **Yes** ❍ **No**

5) Do you have a cardiac pacemaker? ❍ **Yes** ❍ **No**

Women: Are you...

Pregnant/Trying to get pregnant?	❍ **Yes**	❍ **No**
Nursing?	❍ **Yes**	❍ **No**
Taking oral contraceptives?	❍ **Yes**	❍ **No**

Are you allergic to any of the following?

- ❍ Aspirin
- ❍ Metal
- ❍ Barbiturates, sedatives, or sleeping pills
- ❍ Penicillin or Other Antibiotics
- ❍ Latex
- ❍ Iodine
- ❍ Codeine
- ❍ Sulfa Drugs
- ❍ Acrylic
- ❍ Local Anesthetics
- ❍ Other_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	❍ **Yes** ❍ **No**	Shingles	❍ **Yes** ❍ **No**	Cancer	❍ **Yes** ❍ **No**
Alzheimer's Disease	❍ **Yes** ❍ **No**	Sickle Cell Disease	❍ **Yes** ❍ **No**	Chemotherapy	❍ **Yes** ❍ **No**
Anaphylaxis	❍ **Yes** ❍ **No**	Sinus Trouble	❍ **Yes** ❍ **No**	Chest Pains	❍ **Yes** ❍ **No**
Anemia	❍ **Yes** ❍ **No**	Spina Bifida	❍ **Yes** ❍ **No**	Cold Sores/Fever Blisters	❍ **Yes** ❍ **No**
Emphysema	❍ **Yes** ❍ **No**	Stomach/Intestinal Disease	❍ **Yes** ❍ **No**	Ulcers	❍ **Yes** ❍ **No**
Epilepsy or Seizures	❍ **Yes** ❍ **No**	Stroke	❍ **Yes** ❍ **No**	Yellow Jaundice	❍ **Yes** ❍ **No**
Hives or Rash	❍ **Yes** ❍ **No**	Swelling of Limbs	❍ **Yes** ❍ **No**	Radiation Treatments	❍ **Yes** ❍ **No**
Hypoglycemia	❍ **Yes** ❍ **No**	Thyroid Disease	❍ **Yes** ❍ **No**	Recent Weight Loss	❍ **Yes** ❍ **No**
Irregular Heartbeat	❍ **Yes** ❍ **No**	Tonsillitis	❍ **Yes** ❍ **No**	Renal Dialysis	❍ **Yes** ❍ **No**
Kidney Problems	❍ **Yes** ❍ **No**	Tuberculosis	❍ **Yes** ❍ **No**	Rheumatic Fever	❍ **Yes** ❍ **No**
Leukemia	❍ **Yes** ❍ **No**	Parathyroid Disease	❍ **Yes** ❍ **No**	Arthritis/Gout	❍ **Yes** ❍ **No**
Liver Disease	❍ **Yes** ❍ **No**	Venereal Disease	❍ **Yes** ❍ **No**	Excessive Bleeding	❍ **Yes** ❍ **No**
Low Blood Pressure	❍ **Yes** ❍ **No**	Hemophilia	❍ **Yes** ❍ **No**	Excessive Thirst	❍ **Yes** ❍ **No**
Lung Disease	❍ **Yes** ❍ **No**	Hepatitis A	❍ **Yes** ❍ **No**	Fainting Spells/Dizziness	❍ **Yes** ❍ **No**
Mitral Valve Prolapse	❍ **Yes** ❍ **No**	Hepatitis B or C	❍ **Yes** ❍ **No**	Frequent Cough	❍ **Yes** ❍ **No**
Osteoporosis	❍ **Yes** ❍ **No**	Herpes	❍ **Yes** ❍ **No**	Frequent Diarrhea	❍ **Yes** ❍ **No**
Tumors or Growths	❍ **Yes** ❍ **No**	Rheumatism	❍ **Yes** ❍ **No**	Frequent Headaches	❍ **Yes** ❍ **No**
Psychiatric Care	❍ **Yes** ❍ **No**	Scarlet Fever	❍ **Yes** ❍ **No**	Genital Herpes	❍ **Yes** ❍ **No**
Cortisone Medicine	❍ **Yes** ❍ **No**	Artificial Joint	❍ **Yes** ❍ **No**	Glaucoma	❍ **Yes** ❍ **No**
Diabetes	❍ **Yes** ❍ **No**	Asthma	❍ **Yes** ❍ **No**	Hay Fever	❍ **Yes** ❍ **No**
Drug Addiction	❍ **Yes** ❍ **No**	Blood Disease	❍ **Yes** ❍ **No**	Heart Attack/Failure	❍ **Yes** ❍ **No**
Easily Winded	❍ **Yes** ❍ **No**	Blood Transfusion	❍ **Yes** ❍ **No**	Pain in Jaw Joints	❍ **Yes** ❍ **No**
High Blood Pressure	❍ **Yes** ❍ **No**	Breathing Problems	❍ **Yes** ❍ **No**	Convulsions	❍ **Yes** ❍ **No**
High Cholesterol	❍ **Yes** ❍ **No**	Bruise Easily	❍ **Yes** ❍ **No**		

Have you ever had any serious illness not listed?	❍ **Yes**	❍ **No**

If yes:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

X _____ Date: _____

X _____ Date: _____