Dr. Shary Henderson DDS

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Medical History

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre-Med - Amox
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Allergy - Tetracycli
- ☐ Allergy-Erythromycin
- ☐ Arthritis/Rheumatism
- ☐ Blood Disease
- ☐ Chemo/Radiation
- ☐ Epilepsy/Seizures
- ☐ Heart Issues
- ☐ High cholesterol
- ☐ Lung Disease
- ☐ PREMED FOR LIFE
- ☐ Stomach Prob/Ulcers
- ☐ Wears Snore Guard
- ☐ *Pre-Med - Clind
- ☐ Allergy - Carbocaine
- ☐ Allergy - Other
- ☐ Allergy - Vicodin
- ☐ Allergy-Tetracycline
- ☐ Artificial Joints
- ☐ Blood thinner
- ☐ Dementia
- ☐ Epinepherine Reactio
- ☐ Heart Murmur
- ☐ History Blood Clot
- ☐ Oral Cancer
- ☐ Respiratory Problems
- ☐ Stroke
- ☐ *Pre-Med-Cephalexin
- ☐ Allergy - Codeine
- ☐ Allergy - Penicillin
- ☐ Allergy-Acetaminophe
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ Depression
- ☐ Excessive Bleeding
- ☐ Hepatitis/Jaundice
- ☐ Kidney Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Thyroid Condition
- ☐ Allergy - Amoxicilin
- ☐ Allergy - Ibuprofen
- ☐ Allergy - Sulfa
- ☐ Allergy-Clindamycin
- ☐ Anxiety
- ☐ Auto Immune Disease
- ☐ Carbocaine - Use
- ☐ Diabetes
- ☐ Fainting
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Pregnancy
- ☐ Sinus Problems
- ☐ Wears C-pap

*

- ☐ Ever been hospitalized (illness or injury)
- ☐ Tobacco/Alcohol Use
- ☐ Do you snore
- ☐ Presently being treated for any other illnesses
- ☐ FEMALE: Taking birth control pills
- ☐ Do you have Sleep Apnea
- ☐ Subject to frequent headaches
- ☐ FEMALE: Pregnant

LIST ALL MEDICATIONS (INCLUDING VITAMINS AND SUPPLEMENTS)

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain. ◯ Yes ◯ No

If any conditions or alerts selected above need further clarification, please describe below:

Please rate your overall health.

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you exercise regularly? ◯ Yes ◯ No

How many alcoholic drinks do you consume per week? _____

Name of your physician: _____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

Dental History

Check all that apply:

☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ You experience dry mouth
☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
☐ Food gets trapped between any teeth
☐ Have you experienced popping and/or clicking of your jaw joint
☐ Have you ever experienced jaw pain
☐ You have difficulty chewing
☐ You clench or grind your teeth
☐ You wear or have worn a bite appliance
☐ Gums bleed when brushing or flossing
☐ Treated for gum disease or were told you have lost bone around your teeth
☐ Noticed an unpleasant taste or odor in your mouth
☐ Experienced gum recession

Please check any of the following that you have experienced.

☐ Cleanings ☐ Fillings ☐ Deep Cleaning ☐ Gum Treatment ☐ Braces ☐ Crown/Cap ☐ Bridge ☐ Root Canal
☐ Extraction ☐ Implant ☐ Partial ☐ Denture

Is there anything about the appearance of your smile that you would like to change?

Please rate your overall dental health.

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Signature _____ **Date** _____

Response Date: _____