Health History Form

Pearly White Dentistry

Today's Date:

Brittany M. Henry, DDS
R. Gordon Henry, DDS

Patient Information

Patient Name: _________________________________ Home/Cell
Phone:_________________________________

Mailing Address:
____

Date of Birth:_____________________ Gender: M F Prefer to not disclose SS#:___________________________
Marital status: Married Single Divorced Prefer to Not disclose

Emergency Contact:_________________________Relationship:________________Phone:______
If you are completing this for another person:
Name:_________________________________ Relationship to Patient:___________________________
Who may we thank for referring you to our practice?____

Please mark (X) to your responses to the following questions. Check "DK" if you Don't Know the answer the question.

Do you have any of the following diseases or problems:	Yes	No	DK
Active Tuberculosis			
Active COVID-19			
Been exposed to anyone with Tuberculosis:			
Been exposed to anyone with COVID-19:			
Tested positive to COVID-19 within the last 10-14 days			
Persistent cough greater than a 3-week duration			
Cough that produces blood			

Dental Information

Please mark (X) to your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?			
Are your teeth sensitive to cold, hot sweets, or pressure?			
Is your mouth dry?			
Have you had any periodontal (gum) treatments?			
Have you ever had orthodontic (braces) treatment?			
Have you had any problems associated with previous dental treatment?			
Are you currently experiencing dental pain or discomfort?			
Is your home water supply fluoridated?			

	Yes	No	DK
Do you have earaches or neck pains?			
Do you have any clicking, popping, or discomfort in the jaw?			
Do you brux or grind your teeth?			
Do you have sores or ulcers in your mouth?			
Do you wear dentures or partials?			
Do you participate in active recreational activities?			
Have you ever had a serious injury to your head or mouth?			

Do you drink bottled or filtered water?

If yes, how often?

Date of your last dental exam: ____________ Reason for last dental exam: ______________________________

Date of last dental x-rays:_________________

What is the reason for your dental visit today? ____

How do you feel about your smile, or is there anything that you would change about your smile?

____

____

____

Medical Information

Please mark (X) to your responses to the following questions.

	Yes	No	DK
Are you Now under the care of a physician			

Physician Name: Physician Phone Number:

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?			
Date of last physical exam:			
Has there been any change to your general health within the past year?			
If yes, what condition(s) is/are being treated?			
Have you had a serious illness, operation, or been hospitalized in the past 5 years?			
If yes, what was the illness or problem			
Do you wear contact lenses?			
Have you had a total joint replacement? (hip, elbow, knee, finger)			

If yes, what was the date of the surgery? _____________________ Were there any complications? _______________________________

	Yes	No	DK
Are you taking or scheduled to begin taking an antiresorptive agent? (Fozamax, Actonel, Atelva, Boniva, Reclast, Prolia)			
Since 2001, were you treated or are you presently scheduled to begin treatment with antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or matastic cancer?			

	Yes	No	DK
Do you use controlled substances (drugs)?			
Do you use tobacco?			
If you smoke, how many packs per day?			
Do you drink Alcoholic beverages?			

Artificial prosthetic heart valve			
Previous infective endocarditis			
Damaged valves in transplant heart			
Congenital heart disease (CHD)			
(CHD) unrepaired, cyanotic			

(CHD) repaired in last 6 months			
(CHD) repaired with residual defects			
Other congenital heart defects			
Mitral valve prolapse			
Pacemaker			
Rheumatic fever/heart disease			
Abnormal bleeding/anemia/hemophilia			
AIDS or HIV infection			
Autoimmune disease (Rheumatoid arthritis, lupus, Thyroid)			
Respiratory disease (asthma, bronchitis, emphysema, sinus trouble)			
Cancer/Chemotherapy/Radiation treatment			
Diabetes Type I or II			
GI disease (GERD, reflux, persistent heartburn, ulcers)			
Kidney problems			
Neurological disorders (seizures, epilepsy, fainting)			
Hepatitis, jaundice, or liver disease			
Mental disorders			

Other conditions not listed:

Medications:____

____

____

WOMEN ONLY

Taking birth control pills or hormone replacement?			
Nursing?			
Pregnant?			
If yes, number of weeks:			

Allergies

Local Anesthetic		Metals	
Aspirin		Latex	
Penicillin		Iodine	
Sedatives		Seasonal	
Sulfa drugs		Animals	
Codeine		Food	
None		Other	

	Yes	No	DK

Cardiovascular disease			
Angina			
Arteriosclerosis/stroke			
Congestive heart failure			
Damaged heart valve			
Heart attack			
Heart murmur			
High/low blood pressure			
Sleep disorders (sleep apnea, hypopnea)			
Do you snore?			

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian____
Date:__________________________