CARMEL PROFESSIONAL DENTISTRY
DR. C. CROWLEY CORRELL • DR. M. KATHERINE MOORE

Health History Form

Patient Name: _____ DOB: _____ Today's Date: _____

1.) Are you currently under the care of a physician? YES NO

If yes, physicians name: _____Phone Number: _____

2.) Have you ever been hospitalized for a surgical operation or serious illness? YES NO

If yes, please describe illness or problem: _____

3.) Have there been any changes in your general health in the last year? YES NO

If yes, please describe: _____

4.) Do you use alcohol? YES NO If yes, how much:_____ Tobacco? YES NO If yes, how much:_____

5.) WOMEN ONLY: Are you pregnant or think you may be pregnant? YES NO

Are you nursing? YES NO

Are you taking birth control? YES NO

6.) Have you been hospitalized within the last year? YES NO

If so, please explain: _____

7.) Are you allergic to or have any reactions to the following:

Local Anesthetics (e.g. Lidocaine)	YES	NO	Sedatives	YES	NO
Penicillin or other Antibiotics	YES	NO	Latex	YES	NO
Aspirin	YES	NO	Metal/Dyes	YES	NO
Narcotic Drugs (e.g. Percodan)	YES	NO	Other: _____		

Do you, or have you ever had any of the following? (Check all that apply):

- ☐ Acid Reflux
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anxiety
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism/Asperger's
- ☐ Bleeding Disorder
- ☐ Cancer/Malignancy
- ☐ Cerebral Palsy
- ☐ Chemical Dependency
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Frequent Cold Sores
- ☐ Glaucoma
- ☐ Hearing Problems
- ☐ Heart Attack
- ☐ Heart Disease / Murmur
- ☐ Hepatitis
- ☐ High / Low Blood Pressure
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Problems
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Treatment
- ☐ Radiation/Chemo
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers

If applicable, are you required to take a premedication prior to your dental appointment (e.g. joint replacement, mitral valve prolapse, etc.) YES NO DON'T KNOW

If Yes, reason:_____

Medication Information

All Patients: Are you currently taking any of the following? (Check all that apply):

- ☐ Antibiotics/Sulfa Drugs
- ☐ Blood thinners
- ☐ Insulin
- ☐ Recreational Drugs
- ☐ OTC Medications
- ☐ Antihistamines
- ☐ Cancer/Chemo
- ☐ Nitroglycerin
- ☐ Thyroid Medications
- ☐ Daily Aspirin
- ☐ Cortisone/Steroids
- ☐ Oral Contraceptives
- ☐ Tranquilizers
- ☐ BP Medications
- ☐ Heart Medications
- ☐ Diabetic Medications

Please List All Medications Below

Drug Name	Dosage	Reason

Dental Information

1.) Do your gums bleed when you brush or floss? YES NO DON'T KNOW
2.) Are your teeth sensitive to cold, hot, sweets or pressure? YES NO DON'T KNOW
3.) Is your mouth dry? YES NO DON'T KNOW
4.) Have you had any periodontal (gum) treatments? YES NO DON'T KNOW
5.) Have you ever had orthodontic (braces) treatment? YES NO DON'T KNOW
6.) Have you had any problems associated with previous dental treatment YES NO DON'T KNOW
7.) Are you currently experiencing dental pain or discomfort? YES NO DON'T KNOW
8.) Do you have frequent headaches, earaches or neck pains? YES NO DON'T KNOW
9.) Do you have any clicking, popping or discomfort in the jaw? YES NO DON'T KNOW
10.) Do you clench or grind your teeth? YES NO DON'T KNOW
11.) Do you have sores or ulcers in your mouth? YES NO DON'T KNOW
12.) Do you wear dentures or partials? YES NO DON'T KNOW
13.) Have you ever had a serious injury to your head or mouth? YES NO DON'T KNOW

What is the reason for your dental visit today? _____

Date of your last dental exam: _____ Date of last dental x-rays: _____

How do you feel about your smile? _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status, or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

Signature: _____

Relationship to Patient: ☐ Adult Patient ☐ Parent ☐ Guardian ☐ Other