Carmel Professional Dentistry

Health History Form

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

Emergency Contact_____ PH#_____

1.) Do you currently have a primary care physician? YES NO

If yes, physicians name: _____Phone Number: _____

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

If yes, please describe: _____

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

4.) Are you allergic to or have any reactions to Medications YES NO IF YES _____

Latex YES NO

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
- ☐ Bleeding Disorder
- ☐ Cancer/Malignancy
- ☐ Cerebral Palsy
- ☐ Chemical Dependency
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Frequent Cold Sores
- ☐ Glaucoma
- ☐ Hearing Problems
- ☐ Hearing Problems
- ☐ Heart Attack
- ☐ Heart Disease/ Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Problems
- ☐ Low Blood Pressure
- ☐ 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

If yes, reason: _____

Dr. Name_____PH#_____

Medication Information

Are you currently taking any Medications? Yes NO **If Yes Please List All Medications Below:**

Drug Name	Dosage	Reason

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: _____Date:_____

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