BARRINEAU D.D.S.
Family Dental Care & Wellness

Health History

Patient Name_____ **Today's Date**_____

Physician's name_____ **Date of Birth**_____

Please circle Yes (Y), No (N) for your responses(s) to indicate if you have or have not had any off the following diseases or problems

Cardiovascular			If yes, please specify	Neurologic			If yes, please specify
Blood thinner (please select type) (A) Asprin (F) Pradaxa (B) Plavix (G) Effient (C) Eliquis (H) Brilinta (D) Xarelto (I) Savaysa (E) Coumadin/ Warfarin (J) Other	Y	N		Fainting spells	Y	N	When
High/Low Blood Pressure	Y	N	Circle one: High Low	Stroke/CVA	Y	N	Type
Congestive heart failure	Y	N	When	Neuralgia	Y	N	
Rheumatic heart disease	Y	N	When	Shingles	Y	N	
Angina or chest pain	Y	N	Type	Seizures/epilepsy	Y	N	Last time?
Heart surgery	Y	N	When	Paralysis	Y	N	
Coronary bypass surgery	Y	N	Date	Glaucoma	Y	N	
Stents	Y	N	Date	Hearing loss	Y	N	
Myocardial infarction (heart attack)	Y	N	When	Severe headaches	Y	N	
Pacemaker defibrillator	Y	N	When	**Gastrointestinal/Liver**			**If yes, please specify**
Arrhythmias/Atrial fibrillation	Y	N		Stomach Ulcers	Y	N	
Aneurysm	Y	N		Gastritis	Y	N	
Shortness of breath	Y	N		GERD/Reflux	Y	N	
Swollen ankles	Y	N		Hepatitis	Y	N	Type
Cardiac Reasons For Pre-medication							
Have you had a heart transplant?	**Y**	**N**	**Date:**				
Have you had an artificial heart valve?	**Y**	**N**	**Date:**				
Previous infective endocarditis	**Y**	**N**		Liver disease	Y	N	When
Damaged valves in transplanted heart	**Y**	**N**		Jaundice	Y	N	
Congenital heart disease (CHD)	**Y**	**N**		Cirrhosis	Y	N	
Unrepaired cyanotic (CHD)	**Y**	**N**		History of C. difficile	Y	N	When
Repaired (completely) in last 6 months	**Y**	**N**		Chron's disease	Y	N	When
				Ulcerative Colitis	Y	N	When

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Repaired CHD with residual	**Y**	**N**		Ulcerative Colitis	Y	N	When
Hematologic			**If yes, please specify**	**Respiratory**			**If yes, please**
Blood transfusion	Y	N	When	Emphysema	Y	N	O_2 Therapy?
Anemia	Y	N		Bronchitis	Y	N	
Hemophilia	Y	N		Tuberculosis	Y	N	
Leukemia	Y	N	When	Sleep disorders	Y	N	
Sickle cell disease	Y	N	Type				
Immune System			**If yes, please specify**	(Musculoskeletal continued) Osteopenia or	Y	N	
HIV positive	Y	N		Are you or have you taken an anti-resorptive agent for osteoporosis or Paget's disease?..... Yes No If yes, please select from the following: Oral Bisphosphonate (Actonel/Boniva/Fosamax/Atelvia) ☐ Or IV Bisphosphonate (Aredia/Zometa/Bonefos/Reclast/Prolia) ☐			
Sjogren's syndrome	Y	N		**Endocrine**			**If yes, please**
Genitourinary	Y	N	If yes, please specify	Diabetes A1C ≥ 6 in the past 12 months?	Y Y	N N	
Kidney problems	Y	N	Kidney problems	Thyroid disease	Y	N	
				Taking or ever taken steroids?	Y	N	How long?
				Other	Y	N	
Dialysis	Y	N		**Orthopaedic Joint Replacement**			
Sexually transmitted disease	Y	N		**Have you had an orthopaedic total joint (hip, knee, elbow, shoulder replacement?..... Yes No** **Date of implant:_____**			
Human papilloma virus (HPV) positive	Y	N					
Other	Y	N	Specify	**Have you had a joint replacement in the last 6 months?..... Yes**			
Musculoskeletal			**If yes, please specify**	**Have you been advised to pre-medicate for joint replacement……..…… Yes**			
Arthritis	Y	N	Arthritis	**Do you have history of infections with joint replacement?..... Yes**			
Bone disorder	Y	N	Bone disorder	**Have you been told you are immuno-Compromised…….. Yes No** **Orthopaedic surgeon's name:** **Phone #:**			
Muscle disorder	Y	N					
Rheumatoid Arthritis	Y	N	Iv infusions?				
Immunosuppressant drugs	Y	N					
Systemic lupus erythematosus	Y	N					

Patient name:_____ **Date of birth:**_____

	Yes	No
1) Are you in good health?.....	Y	N
If no or don't know, please explain?		
Allergies: Are you allergic to or have you had a reaction to any of the following? **To all yes response, specify types of reaction.**		
Latex_____	Y	N
Penicillin_____	Y	N
Other antibiotics_____	Y	N
General anesthetics_____	Y	N
Local anesthestics_____	Y	N
Aspirin_____	Y	N
Codeine or other narcotics_____	Y	N
2) Are you now under the care of a physician?.....	Y	N
If yes, what is/are the conditions being treated?		
Physician or Clinic name: Phone:		
3) Has a previous physician dentist recommended that you take antibiotics prior to your dental treatment?.....	Y	N
Name of referring Doctor: _____ Phone Number:		
4) Have there been any changes in your general health within the past year?.....	Y	N
If yes, please explain?		
5) Have you had any serious illness, operation, organ transplant or been hospitalized in the past 5 years?.....	Y	N
If yes, Illness or problem?		
6) Do you drink alcoholic beverages?.....	Y	N
If yes, how much do you typically drink in a week? _____		
Are you alcohol dependent?.....	Y	N
If yes are you receiving treatment?.....	Y	N

	Yes	No
(allergies continued)		
Iodine_____	Y	N
Any other drugs_____	Y	N
Metal(s) Specify_____	Y	N
Food(s) Specify_____	Y	N
Other(s) Specify:		
8) Do you use drugs or other substances for recreational purposes?.....	Y	N
Frequency or use (daily, weekly, etc): _____		
Are you drug dependent?.....	Y	N
Number of years of recreational drug use?_____		
If yes, are you receiving treatment?.....	Y	N
Do you smoke, use smokeless tobacco or vape?.....	Y	N
If yes, type, how much/often, packs per day? _____		
If yes, how interested are you in stopping?.....	Y	N
For Children:		
History of finger, thumb, blanket or pacifier sucking.....	Y	N
History of dental anxiety?.....	Y	N
Any other oral habits (specify):		
WOMEN ONLY		
Are you or could you be pregnant?.....	Y	N
Number of weeks:		

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7) Have you had cancer, tumor, or malignancy?..... Y N If yes, type, when, treatment?	Number of weeks:_____ Nursing?..... Y N Taking birth control pills or hormonal replacement?..... Y N

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

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 inquires 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:	Today's Date:	Doctor's signature:

First review date:_____ Patient signature_____ Doctor's signature_____

Second review date:_____ Patient signature_____ Doctor's signature_____

Third review date:_____ Patient signature_____ Doctor's signature_____

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