HEALTH HISTORY

Patient Name _____Date_____

Physician's Name & Phone Number_____Date of Last Visit_____

Please check "Yes" or "No" if you have had any of the following: Date of Birth_____

Autism/ Asperger Syndrome/ ASD	❑Yes	❑No
AIDS/ HIV +	❑Yes	❑No
Anemia	❑Yes	❑No
Arthritis/Rheumatism	❑Yes	❑No
Artificial Joints	❑Yes	❑No
Asthma	❑Yes	❑No
Last Attack Date_____		
Hospitalized	❑Yes	❑No
Back/Neck Pain	❑Yes	❑No
Bleeding Abnormally, w/Extractions, Surgery	❑Yes	❑No
Blood Disease	❑Yes	❑No
Cancer	❑Yes	❑No
Radiation Treatment	❑Yes	❑No
Chemotherapy	❑Yes	❑No
Chemical Dependency	❑Yes	❑No
Circulatory Problems	❑Yes	❑No
Chest Pain/Angina	❑Yes	❑No
Cortisone (Steroid) Treatment	❑Yes	❑No
Persistent Cough/Cough Up Blood	❑Yes	❑No
Diabetes/Sugar Levels	❑Yes	❑No
Dry Mouth	❑Yes	❑No
Sjögren's Syndrome	❑Yes	❑No
Eating Disorders	❑Yes	❑No
Emphysema	❑Yes	❑No
Epilepsy/Seizure Disorders	❑Yes	❑No
Fainting/Dizziness	❑Yes	❑No
Glaucoma	❑Yes	❑No
Headache/Migraines	❑Yes	❑No
Any of the following heart conditions?		
Artificial heart valves	❑Yes	❑No
A history of infective endocarditis	❑Yes	❑No
Pacemaker:	❑Yes	❑No
Date Placed_____		
Indwelling Defibrillator	❑Yes	❑No
In the last 6 months, have you had:		
• unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits	❑Yes	❑No
Certain specific, serious congenital (present from birth) heart conditions, including		
• a completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention	❑Yes	❑No
• any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or a prosthetic device	❑Yes	❑No
• a cardiac transplant that developed a problem in a heart valve	❑Yes	❑No
Hepatitis: Type_____	❑Yes	❑No
High Blood Pressure/Low Blood Pressure	❑Yes	❑No

History of Organ Transplant	❑Yes	❑No
History Osteoporosis/Osteopenia	❑Yes	❑No
Have you ever taken:		
Oral Bisphosphonate (Actonel/Boniva/Fosamax)	❑Yes	❑No
IV Bisphosphonate (Aredia/Zometa/Bonefos)	❑Yes	❑No
Nervous Problems	❑Yes	❑No
Psychiatric Care	❑Yes	❑No
Respiratory Disease	❑Yes	❑No
Shortness of Breath	❑Yes	❑No
Sinus Trouble	❑Yes	❑No
Thyroid Problems	❑Yes	❑No
Sleep Apnea	❑Yes	❑No
Tuberculosis (Self/Family Member)	❑Yes	❑No
Tumor or growth on Head or Neck	❑Yes	❑No
Stroke	❑Yes	❑No
Reflux/GERD	❑Yes	❑No
Stomach Ulcer/Stomach Problems	❑Yes	❑No
Venereal Disease	❑Yes	❑No
Have you taken Fen Phen/Redux?	❑Yes	❑No
Herpes	❑Yes	❑No
History Head/Neck/Mouth Trauma	❑Yes	❑No
Women:		
Are you pregnant?	❑Yes	❑No
Date Due _____		
Nursing?	❑Yes	❑No
Birth Control Pills	❑Yes	❑No

Any other condition not listed above:

_____

_____

_____

ALLERGIES

❑ Aspirin	❑ Local Anesthetic
❑ Red Wine	❑ Metals
❑ Barbiturates	❑ Penicillin
❑ Codeine	❑ Sulfa
❑ Iodine	❑ Latex
❑ Sulfites	❑ Other_____

MEDICATIONS

List medications you are currently taking:

Date	Medication	Dosage	Frequency

MEDICAL TREATMENT REVIEW (for office use)

_____

_____

_____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Barrineau and staff to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Barrineau. Since at each visit the work to be done is explained to me prior to treatment, I give Dr. Barrineau my consent to perform any needed dental treatment.

Signature_____ Date_____