BARRINEAU D.D.S. P.A.
Family and Cosmetic Dentistry

Health History

Patient Name_____ **Today's Date**_____
Date of Birth_____

Please indicate your response with (X) under the corresponding box (Y) for YES and (N) for NO

Cardiovascular	Y	N	If yes, please specify:
Blood thinner (please select type) (A) Aspirin (F) Pradaxa (B) Plavix (G) Effient (C) Eliquis (H) Brilinta (D) Xarelto (I) Savaysa (E) Coumadin/Warfarin			Other:
High/Low Blood Pressure			Select One: High Low
Congestive heart failure			
Rheumatic heart disease			When:
Angina or chest pain			
Heart surgery			When:
Coronary bypass surgery			Date:
Stents			
Myocardial infarction (heart attack)			
Pacemaker defibrillator			When:
Arrhythmias/Atrial fibrillation			
Aneurysm			
Shortness of breath			
Swollen ankles			
Cardiac Reasons for Pre-medication			
Have you had a heart transplant?			
Have you had an artificial heart valve?			
Previous infective endocarditis?			
Damaged valves in transplanted heart?			
Congenital heart disease (CHD)			
Unrepaired cyanotic (CHD)			
- Repaired (completely) in last 6 months?			
- Repaired CHD with residual defects?			

Hematologic	Y	N	If yes, please specify:
Blood transfusion			When:
Anemia			
Hemophilia			

Neurologic	Y	N	If yes, please specify:
Fainting spells			When:
Stroke/CVA			Type:
Neuralgia			
Shingles			
Seizures/Epilepsy			Last Time?
Paralysis			
Glaucoma			
Hearing loss			
Severe headaches			
Gastrointestinal/Liver	**Y**	**N**	**If yes, please Specify:**
Stomach ulcers			
Gastritis			
GERD/Reflux			
Hepatitis			Type:
Liver disease			When:
Jaundice			
Cirrhosis			
History of C. difficile			When:
Chron's disease			
Ulcerative Colitis			When:
Respiratory	**Y**	**N**	**If yes, please specify:**
Emphysema			O_2 Therapy?
Bronchitis			
Tuberculosis			
Sleep disorders			

Have you been advised that you **CURRENTLY** require any antibiotic prophylaxis for dental procedures/treatment?..... **Yes** **No**

If yes, why?

1) **Have you had cancer, tumor, or malignancy?..... Y N**

   If yes, type, when, treatment?

2) **Have you had any serious illness, operation, organ transplant or been hospitalized in the past 5 years?..... Y N**

   If yes, illness or problem?

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

Immune System	Y	N	If yes, please specify:
HIV positive			
Sjogren's syndrome			
Genitourinary			
Kidney problems			
Dialysis			
Sexually transmitted disease/infections			
Human papillomavirus (HPV) positive			
Other			

Endocrine	Y	N	If yes, please specify:
Diabetes A1C ≥ 6 in the past 12 months?			
Thyroid disease			
Taking or have ever taken steroids for longer than 2 weeks at a time?			

Do you take Immunosuppressant or Biologic Medications:

Embrel/Humira/Remicade/Avastin…… **Yes** **No**

Other: _____

Musculoskeletal	Y	N	If yes, please specify:
Arthritis			
Bone disorder			
Muscle disorder			
Rheumatoid Arthritis			Where:
Systemic Lupus			

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)

___ IV Bisphosphonate (Aredia/Zometa/Bonefos/Reclast/Prolia)

Orthopedic Joint Replacement

Have you had an orthopedic total joint (hip, knee, elbow, shoulder) Replacement?..... Yes No

Date of Implant:_____

Location:_____

Have you had a joint replacement in the last 6 months?..... Yes No

Do you have history of infections with joint replacement?..... Yes No

Orthopedic surgeon's name: _____

Allergies: Are you allergic to or have you had a reaction to any of the following?

If "YES", specify type of reaction:

Latex_____	Y	N
Penicillin_____	Y	N
Local anesthetics_____	Y	N
Aspirin_____	Y	N
Sulfa Drugs_____	Y	N
Codeine or other narcotics _____	Y	N

(Allergies continued)

Metal(s) Specify_____	Y	N
Food(s) Specify_____	Y	N
Other Antibiotic / Medication Allergies:	Y	N

Specify:

_____

Women ONLY:

Currently taking Birth Control?.....	Yes	No
Are you pregnant?.....	Yes	No

If so, Due date:_____

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 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 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**

Second Review Date:_____ Patient Signature_____