Time 2:18 PM | Barnes Dental,LLC | Date 5/24/2022

Health History 2022

Patient Name: | Birth Date: | Date Created:

Dental History

Are you currently experiencing any dental pain or discomfort?	Yes No	If yes
Has a physician or previous dentist recommended that you take antibiotics before having dental work?	Yes No	If yes

Are you taking any blood thinners (such as Coumadin, Warfarin, Xarelto, Pradaxa, Plavix, heparin or aspirin?	Yes No	If yes
Are you taking any medication to treat osteoporosis or Paget's disease?	Yes No	If yes
Are you taking hormonal replacement?	Yes No	If yes
Do you use any form of tabacco or nicotine products?	Yes No	If yes
Do you use vaping products?	Yes No	If yes
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons?	Yes No	If yes
Do you take any other prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements?	Yes No	If yes

Are you allergic to or have you had an allergic reaction to:

Aspirin	Yes No	Barbiturates, sedative or sleeping pills	Yes No	Codeine or other narcotics	Yes No
Hay fever/seasonal allergies	Yes No	Iodine	Yes No	Latex (rubber)	Yes No
Local anesthetics	Yes No	Metals	Yes No	Penicillin or other antibiotics	Yes No
Sulfa drugs	Yes No				

Other	Yes No	If yes

WOMEN ONLY: Are you:

Taking birth control pills?	Yes No	
Pregnant: If yes number of weeks:	Yes No	If yes
Nursing: If yes number of weeks:	Yes No	If yes

Physician's name and phone number	Yes No	If yes

General Questions

Have you had a serious illness, operation or been hospitalized in the past 5 years	Yes No	Have you had any type (total or partial) joint replacement	Yes No
Have you had a heart valve replacement or heart surgery	Yes No	Have you had an organ or bone marrow/stem cell transplant	Yes No
Have you traveled internationally within the last 30 days	Yes No	Have you had a fever (100.4) in the last 72 hours	Yes No

If you have answered yes to any of these questions please explain	☐	If yes

Do you have, or have you been diagnosed with, any of the following conditions?

Pacemaker/implanted defibrillator	Yes No	Cancer	Yes No	Gastronintestinal disease	Yes No
Artificial heart valve	Yes No	Chemotherapy	Yes No	G.E. reflux/persistent heartburn (GERD)	Yes No
Previous infective endocarditis	Yes No	Radiation Treatment	Yes No	Stomach ulcers	Yes No
Congenital heart disease	Yes No	Anemia	Yes No	Glaucoma	Yes No
Arteriosclerosis	Yes No	Blood Transfusion	Yes No	Arthritis	Yes No
Coronary artery disease	Yes No	Hemophilia	Yes No	Chronic pain	Yes No
Congestive heart failure	Yes No	High or low blood pressure	Yes No	Diabetes (type I or II)	Yes No
Damaged heart valves	Yes No	Anxiety	Yes No	Eating Disorder	Yes No
Heart Attack	Yes No	Depression	Yes No	Frequent infections	Yes No
Heart murmur/rhythm disorder	Yes No	Epilepsy	Yes No	Hepatitis, jaundice, or liver disease	Yes No
Rheumatic heart disease	Yes No	Mental health disorder	Yes No	Immune deficiency	Yes No
Stroke	Yes No	Neurological disorders	Yes No	Kidney Problems	Yes No
Asthma	Yes No	Post-traumatic stress disorder	Yes No	Malnutrition	Yes No
Bronchitis	Yes No	Traumatic brain injury or concussion	Yes No	Osteoporosis	Yes No
Emphysema	Yes No	AIDS or HIV infection	Yes No	Sexually transmitted infection	Yes No
Sinus Trouble	Yes No	Lupus	Yes No	Thyroid problems	Yes No
Tuberculosis	Yes No	Migraines or severe headaches	Yes No		

Do you have any disease,condition, or problem not listed here? If so, please explain	Yes No	If yes

Comments

Signature of Patient, Parent or Guardian:

X Date:_____

Signature of Provider:

X Date:_____