CONFIDENTIAL HEALTH HISTORY

Patient Name:_____**Preferred Name**:_____ **Date of Birth** :_____
How do you prefer to be addressed? Circle one: By first name/Preferred Name/Ms/Mrs/Mr/Dr.
What pronouns do you prefer we use when talking about you? Circle all that apply: **She/her/hers**, **He/him/his, They/them/theirs, Othe**r Please specify:_____

Who may we thank for referring you?_____

CIRCLE APPROPRIATE ANSWER (Leave blank you do not understand the question)
Are you in good general health? If NO, please explain: **Y** **N**

_____
Has there been a change in your health within the last year? **Y** **N**
If YES, please explain:_____
Have you gone to the hospital or emergency room, or had a serious illness in the last 3 years? **Y** **N**
If YES, please explain:_____
Are you being treated by a physician now for a specific condition? **Y** **N**
If YES, please explain:_____
Have you had any problems with prior dental treatment? **Y** **N**
If YES, please explain:_____
Are you in any pain now? **Y** **N**
If YES, please explain:_____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (PLEASE CIRCLE)

Chest pain (angina)	Blood in stools	Frequent vomiting
Fainting spells	Diarrhea or constipation	Jaundice
Rapid weight loss	Frequent urination	Dry mouth
Fever	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing
Coughing up blood	Headaches	Swollen ankles
Persistent cough	Dizziness	Joint pain or stiffness
Bleeding problems	Blurred vision	Shortness of breath
Blood in urine	Bruise easily	Sinus problems

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (PLEASE CIRCLE)

AIDS/HIV	Heart attack	Rheumatism
Anemia	Heart disease/defects	Rheumatic Fever
Artificial joints	Hepatitis	Seizures
Asthma	Herpes (canker/cold sores)	Sexually Transmitted Disease
Cancer	High blood pressure	Skin disease
Chemotherapy	Hospitalization	Stomach problems or ulcers
Cosmetic surgery	Kidney or bladder disease	Stroke
Diabetes	Liver disease	Surgeries
Eating disorder	Low blood pressure	Thyroid Disease
Emphysema or other lung disease	Osteoporosis	Transplants
Eye disease	Psychiatric care	Tuberculosis
Family history of heart disease	Radiation treatment	Tumors

DO YOU OR HAVE YOU HAD HEART MURMURS*? Y N

***Guidelines below are from The American Heart Association:**

Antibiotic prophylaxis with dental procedures is recommended only for patients with cardiac conditions associated with the highest risk of adverse outcomes from endocarditis, including:

- **Prosthetic cardiac valve**
- **Previous endocarditis**
- **Congenital heart disease only in the following categories:**
  - **Unrepaired cyanotic congenital heart disease, including those with palliative shunts and conduits.**
  - **Completely repaired congenital heart disease with prosthetic nmaterial or device, whether placed by surgery or catheter intervention during the first six months after the procedure***
  - **Repaired congenital hear disease with residual defects at the sire or adjacent to the site of a prosthetic patch or prosthetic device (which inhibits endothelialization).**
- **Cardiac transplantation recipients with cardiac vascular disease.**

Prohylaxis is recommended because endotheliazation of prosthetic material occurs within 6 months after the procedure.

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (PLEASE CIRCLE)

Amoxicillin	Iodine	Tetracycline
Aspirin	Latex	Valium
Clindamycin	Local Anesthetics	Vicodin
Codeine	Metals	Other:_____
Darvon	Nitrous Oxide	_____
Demerol	Penicillin	No Known Drug Allergies
Erythromycin	Percodan	

ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (PLEASE CIRCLE)

Alcohol	Antibiotics	Aspirin	Bisphosphonate (Fosamax)
Over-the-counter Medications		Recreational Drugs	
Supplements	Tobacco in any form		

PLEASE LIST OR ATTACH ANY MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

WOMEN ONLY:

Are you or could you be pregnant? Y N

If yes what is your due date? _____/_____/_____

Are you nursing? Y N

Are you taking birth control pills? Y N

ALL PATIENTS:

Do you have or have you had any other diseases or medical conditions NOT listed on this form? Y N

If YES, please explain:

_____

_____

ALL PATIENTS CONTINUED:

Have you ever or do you require to **pre-medicate** with antibiotics prior to dental treatment? **Y** **N**

If YES, please explain why:_____

Have you ever taken **Fen-phen**? **Y** **N**

If YES, when?:_____

In case of an emergency, who can we contact? Name:_____

Relationship:_____ Phone number:_____

Are there any issues or conditions you would like to discuss with the dentist privately? ***YES*** ***NO***

The practice of dentistry involves the treatment of the whole person. If Dr. Gavros determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment. I therefore authorize D. Gavros to contact my Primary Care Physician.

Patient's Signature (Parent/Guardian):_____ **Date:**_____

Physician's Name:_____ **Phone Number:**_____

I certify that I have read and understand this form. To the best of my knowledge I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold Dr. Gavros, associate Dentist, or any other member of her staff responsible for any errors or omissions that I have made in the completion of this form.

Patient's Signature (Parent/Guardian):_____ **Date:**_____

Signature of Licensed Provider:_____ **Date:**_____