

Dr. Drew S. Griffith

PATIENT NAME _____ DATE: _____

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

Do you have a specific dental problem? Describe _____ Y N
 Do you have dental examinations on a routine basis? Last visit _____ Y N
 Do you think you have active decay or gum disease? _____ Y N
 Do your gums ever bleed? Discuss _____ Y N
 Do you like your smile? Why? _____ Y N
 Does food catch between your teeth? Any Loose Teeth? _____ Y N
 Do you want to keep your remaining teeth? _____ Y N
 Do you ever have clicking, popping or discomfort in the jaw joint?
 Do you brux or grind? _____ Y N
 Have your past experiences in a dental office always been positive? _____ Y N
 Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Y N
 Name of previous dentist (optional): _____ Y N
 Date of last full mouth x-rays (16 small films or panoramic): _____ Y N

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Y N
 Have you ever been hospitalized or had a major operation? Discuss _____ Y N
 Have you ever had a serious injury to your head or neck? Discuss _____ Y N
 Are you taking any medications, pills or drugs? What? _____ Y N
 Are you on a special diet? Discuss _____ Y N
 Are you allergic to any medications or substances? Please check box below _____
 Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other
 Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives
 Discuss _____ Y N

Do you now have or have you ever had any of the following? Please Circle "YES" or "NO" to each item. * If yes to any of the starred conditions, please call prior to your appointment... premedication maybe required.

Heart Disease Surgery*... Y N	Leukemia Y N	Diabetes... Y N	Tattoos/Body Piercing Y N
Heart Murmur*... Y N	Recent Blood Transfusion Y N	Excessive Thirst... Y N	Cold Sores... Y N
Irregular Heart Beat... Y N	Swelling of Limbs... Y N	Hypoglycemia... Y N	Fever Blister... Y N
Angina/Chest Pain... Y N	Lung Disease... Y N	Liver Disease... Y N	Herpes... Y N
Heart Attack/Failure... Y N	Breathing Problem... Y N	Hepatitis A (Infectious)... Y N	Stroke... Y N
Congenital Heart Disorder Y N	Shortness of Breath... Y N	Hepatitis B or C... Y N	Convulsions... Y N
Mitral Valve Prolapse*... Y N	Frequent Cough... Y N	Night Sweats... Y N	
Scarlet Fever... Y N	Hay Fever... Y N	Yellow Jaundice... Y N	Fainting or Dizziness... Y N
Rheumatic Fever *... Y N	Sinus Trouble... Y N	Kidney Problems... Y N	Glaucoma... Y N
Artificial Heart Valve*... Y N	Asthma... Y N	Renal Dialysis... Y N	Tumors or Growths... Y N
Heart Pace Maker*... Y N	Bloody Sputum... Y N	Thyroid Disease... Y N	Nervousness... Y N
Pulmonary Shunt... Y N	Emphysema... Y N	Parathyroid Disease Y N	Psychiatric Care... Y N
High Blood Pressure... Y N	Tuberculosis... Y N	Arthritis/Gout... Y N	Alzheimer's disease... Y N
Low Blood Pressure... Y N	Cancer... Y N	Rheumatism... Y N	Allergies (Medicines)... Y N
Bacterial Endocarditis Y N	X-Ray Treatments (Radiation)... Y N	Pain In Jaw Joints... Y N	Allergies (Pollen/Dust)... Y N
Unexplained Fever... Y N	Chemotherapy... Y N	Cortisone Medicine... Y N	Hives or Rash... Y N
Bruise Easily/Blood Disease... Y N	Aredia I.V... Y N	Artificial Joint*... Y N	Need Premedication?... Y N
Anemia... Y N	Zometa I.V... Y N	Venereal Disease... Y N	Ever taken fen-phen?... Y N
Excessive Bleeding... Y N	Stomach/Intestinal Disease Y N	AIDS... Y N	
Sickle Cell Disease Y N	Ulcers... Y N	HIV Positive... Y N	
Hemophila(Bleeding Problem Y N	Recent Weight Loss... Y N	Genital Herpes... Y N	
	Frequent Diarrhea... Y N	Drug Addiction/Alcoholism... Y N	

Have you ever had any other serious illness not checked above?
 Discuss _____ Y N

Do you wish to talk to the dentist privately about any problem? _____ Y N

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
 PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____

History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
_____	_____	None	<input type="checkbox"/>	_____	_____	_____
_____	_____	None	<input type="checkbox"/>	_____	_____	_____
_____	_____	None	<input type="checkbox"/>	_____	_____	_____
_____	_____	None	<input type="checkbox"/>	_____	_____	_____
_____	_____	None	<input type="checkbox"/>	_____	_____	_____
_____	_____	None	<input type="checkbox"/>	_____	_____	_____

DENTAL AND MEDICAL HISTORIES - UPDATES