Brad W. Griffin, DDS

Medical History

Patient Name____________________________ Birth Date________
Are you under the care of a physician?_________________________
Condition?____
Have you been hospitalized or had a major operation?
____
Have you ever had a serious head or neck injury?
____
Are you taking any medications, pills, or drugs?
____

Do you take, or have you taken, Phen-Fen or Redux? _____________
Have you taken Fosamax, Boniva, Actonel or any other bisphosphonates? ____
Are you on a special diet?_________Do you use tobacco?_________
Controlled substances?____________________________________
Are you allergic to any of the following: Aspirin Penicillin Codeine Local Anesthetics Metal Latex Sulfa Drugs Other_______________
Women: Taking Oral Contraceptives?____Pregnant____Nursing____

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	Y N	Diabetes	Y N	Hepatitis A	Y N	Recent Weight Loss	Y N
Alzheimer's disease	Y N	Drug Addiction	Y N	Hepatitis B or C	Y N	Renal Dialysis	Y N
Anemia	Y N	Easily Winded	Y N	Herpes	Y N	Rheumatic Fever	Y N
Angina	Y N	Emphysema	Y N	High Blood Pressure	Y N	Scarlet Fever	Y N
Arthritis/Gout	Y N	Epilepsy or Seizures	Y N	High Cholesterol	Y N	Shingles	Y N
Artificial Heart Valve	Y N	Excessive Bleeding	Y N	Hives or Rash	Y N	Sickle Cell Disease	Y N
Artificial Joint	Y N	Excessive Thirst	Y N	Hypoglycemia	Y N	Sinus Trouble	Y N
Asthma	Y N	Fainting	Y N	Irregular Heartbeat	Y N	Spina Bifida	Y N
Blood Disease	Y N	Spells/Dizziness	Y N	Kidney Problems	Y N	Stomach Disease	Y N
Blood Transfusion	Y N	Frequent Cough	Y N	Leukemia	Y N	Stroke	Y N
Breathing Problems	Y N	Frequent Diarrhea	Y N	Liver Disease	Y N	Swelling of Limbs	Y N
Bruise Easily	Y N	Frequent Headaches	Y N	Low Blood Pressure	Y N	Thyroid Disease	Y N
Cancer	Y N	Glaucoma	Y N	Lung Disease	Y N	Tonsillitis	Y N
Chemotherapy	Y N	Hay Fever	Y N	Mitral Valve Prolapse	Y N	Tuberculosis	Y N
Chest Pains	Y N	Heart Attack/Failure	Y N	Osteoporosis	Y N	Tumors or Growths	Y N
Cold Sores/Fever Blisters	Y N	Heart Murmur	Y N	Pain Jaw Joints	Y N	Ulcers	Y N
Congenital Heart Disorder	Y N	Heart Pacemaker	Y N	Parathyroid Disease	Y N	Yellow Jaundice	Y N
Convulsions	Y N	Heart Disease	Y N	Psychiatric Care	Y N		
Cortisone Medicine	Y N	Hemophilia	Y N	Radiation Treatment	Y N		

Have you ever had any serious illness not listed above?____Date_______________

Dental History

Reason for Visit / Main Concern?
____

When did you last visit a dentist? ____________ What treatment was performed?_________________________

Was the treatment completed? YES_____NO_____. Were dental x-rays taken? YES_____NO_____

Did you have a cleaning? YES___NO___

Have you had gum (periodontal) treatment? YES_____ NO_____

Have you ever had prolonged bleeding after an extraction? YES _____ NO_____

Have you had any problems with past dental treatment? YES_____ NO_____

Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES____NO___

Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES_____ NO_______

Do your gums bleed easily? YES___NO___

Do you feel you have bad breath? YES_____NO_____

Are your teeth sensitive to hot or cold? YES_____ NO___

Would you like your teeth whiter? YES_____NO_____

Any other dental procedure that you would like to know more about?
____