Medical Sheet Update:

Dr. Daniel Griffiths

Patient Name:_____ If there are changes Phone#_____

Address:_____ _____City, St, Zip _____

1. Approximate date of last dental visit and treatment preformed? _____

_____

2. Please list any over-the-counter medications, prescriptions or herbal supplements you are taking now.

_____ _____ _____

_____ _____ _____

3. Please circle if you have had an allergy or reaction to? Penicillin Aspirin Latex Tetra/Doxycycline

Other Drug Allergies_____

Describe the reaction_____

4. Have you ever been told to take an antibiotic before a dental appointment? _____

If so, were you told why? _____

Circle YES or NO to any that apply to you now or in the past:

Low Blood pressure	YES NO	Anorexia/Bulimia	YES NO	Diet/Restrictions	YES NO
High Blood pressure	YES NO	Diabetes	YES NO	AIDS	YES NO
Chest Pain	YES NO	Thyroid Problems	YES NO	HIV positive	YES NO
Heart Disease	YES NO	Heart Attack	YES NO	Heart Surgery	YES NO
Ulcers	YES NO	Hepatitis A,B,C	YES NO	Contact Lenses	YES NO
Glaucoma	YES NO	Heart Murmur	YES NO	Emphysema	YES NO
Blood Transfusion	YES NO	Mitral Valve Prolapse	YES NO	Chronic Cough	YES NO
Hemophilia	YES NO	Artificial Heart Valve	YES NO	Tuberculosis	YES NO
Sickle Cell Disease	YES NO	Heart Pacemaker	YES NO	Asthma	YES NO
Bruise Easily	YES NO	Rheumatic Fever	YES NO	Hay Fever	YES NO
Liver Disease	YES NO	Arthritis/Rheumatism	YES NO	Epilepsy/Seizures	YES NO
Kidney Disease	YES NO	Cortisone Meds	YES NO	Stroke	YES NO
Swollen Ankles	YES NO	Sinus Trouble	YES NO	Neurological Disorder	
Radiation Therapy	YES NO	Allergies or Hives	YES NO		YES NO
Artificial-Hip/Knee	YES NO	Fainting/Dizzy	YES NO	Clinching/Grinding	YES NO
Chemotherapy	YES NO	Tumors	YES NO	Cancer	YES NO
Nervous/Anxious	YES NO	Dental Implants	YES NO	Psychiatric Care	YES NO
Psychological Care	YES NO	Tobacco Use	YES NO		

5. Have you traveled to: Liberia, Sierra Leone or Guinea in the last 21 days? YES NO

If YES, please let us know when you arrived into the U.S.?

Month_____ Day _____

6. Are you feeling feverish? YES NO

7. Do you have a disease, condition or problem not listed? YES NO

If YES what? _____

8. WOMEN: Pregnant? YES NO Taking Birth Control YES NO

ARE THERE ANY MEDICAL ALERTS WE SHOULD BE AWARE OF NOT MENTIONED?

_____ _____

Signature Date

Midtown Dentistry