Medical History

Patient Name_____Date of birth_____

Are you under a physician's care now? **Yes** **No** If yes, please explain:_____

Have you ever been hospitalized or had a major operation? **Yes** **No** If yes, please explain:_____

Have you ever had a serious head or neck injury? **Yes** **No** If yes, please explain:_____

Do you take **Bisphosphenates or have you ever** taken Bisphosphenates? (Fosamax, Boniva or Actonel) **Yes** **No**

Women: Are you pregnant or suspect you might be pregnant? **Yes** **No** Nursing? **Yes** **No** Taking oral contraceptives? **Yes** **No**

Do you have any pins, screws, rods or plates in your body? If so explain_____

Do you have any artificial heart valves and/or artificial joints? Date of Surgery_____

Please list any medications, supplements or herbs you are taking._____

Are you allergic to any of the following?

( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Acrylic ( ) Metal ( ) Latex ( ) Local Anesthetics ( ) Other_____

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

( ) AIDS/HIV Positive	( ) Congenital Heart Disorder	( ) Heart Trouble/Disease	( ) Recent Weight Loss
( ) Alzheimer's disease	( ) Steroid Medicine	( ) Hemophilia	( ) Renal Dialysis
( ) Anaphylaxis	( ) Diabetes	( ) Hepatitis A, B or C	( ) Rheumatic Fever
( ) Anemia	( ) Drug Addiction	( ) High Blood Pressure	( ) Rheumatism
( ) Angina	( ) Emphysema	( ) Hives or Rash	( ) Scarlet Fever
( ) Arthritis/Gout	( ) Epilepsy or Seizures	( ) Hypoglycemia	( ) Shingles
( ) Artificial Heart Valve	( ) Excessive Bleeding	( ) Irregular Heartbeat	( ) Sickle Cell Disease
( ) Artificial Joint	( ) Excessive Thirst	( ) Kidney Problems	( ) Sinus Trouble
( ) Asthma	( ) Fainting/Dizziness	( ) Leukemia	( ) Stomach/Intestinal Disease
( ) Blood Disease	( ) Frequent Cough	( ) Liver Disease	( ) Stroke
( ) Breathing Problems	( ) Frequent Headaches	( ) Low Blood Pressure	( ) Swelling of Limbs
( ) Bruise Easily	( ) Glaucoma	( ) Lung Disease	( ) Thyroid Problems
( ) Cancer	( ) Hay Fever	( ) Mitral Valve Prolapse	( ) Tuberculosis
( ) Chemotherapy	( ) Heart Attack/Failure	( ) Pain in Jaw Joints	( ) Tumors or Growths
( ) Chest Pains	( ) Heart Murmur	( ) Psychiatric Care	( ) Ulcers
( ) Cold Sores/Fever Blister	( ) Heart Pace Maker	( ) Radiation Treatment	( ) Venereal Disease

Dental History

Reason for this Visit?_____

When was your last dental visit?_____

Why did you change dentists?_____

Previous Dentist (name and location)_____

If you could change anything about your smile, what would you change?_____

_____

I certify that the information I have provided for myself or my minor child, including the health questionnaire, is correct to the best of my knowledge. I authorize Dr. Braymen to perform dental treatment on me or my minor child.

Signature _____Date _____