BRAFMAN
FAMILY DENTISTRY

KEVIN H. BRAFMAN D.D.S. WENDY W. BRAFMAN D.D.S.

MEDICAL HISTORY

Name_____ Date of Birth_____

How is your current health **Good** **Fair** **Poor** Current Physician _____

Have you had any joint replacements? **Y or N** Circle: **Knee** **Hip** **Shoulder**

Have you had previous Head or Neck Cancer or Radiation Treatments? **Y or N**

Oncologist Doctor: _____ Where Treatment was given: _____

Have you ever taken any Osteoporosis Medications? Fosamax or any bisphosphonates? **Y or N**

Have you ever had open heart surgery, valve replacement surgery, stents, pacemaker, or heart related surgeries? **Y or N**

Describe: _____

List of hospitalizations and surgeries: _____

_____

Are you currently taking a blood thinner? **Y or N**

Are you an insulin dependent diabetic? **Y or N**

For Women: Are you Pregnant? **Y or N** , Week #____ Are you Nursing? **Y or N** Taking Birth Control **Y or N**

Are you allergic to any of the following? **Latex** **Penicillin/Amoxicillin** **Codeine** **Aspirin** **Tetracycline** **Dental Anesthetics**

Others: _____

Please list all medications that you are currently taking, prescription and over the counter:
(We can make a copy if you have a current list for your chart)

_____

_____

Do you have or have you been previously diagnosed with any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke
Y N Heart Surgery /Pacemaker
Y N Heart Murmur
Y N Hepatitis
Y N Liver Problems
Y N Artificial Heart Valves
Y N Heart Disease
Y N Congentital Heart Defect
Y N Shingles
Y N Anemia
Y N Fainting/Seizures/Epilepsy
Y N Arthritis/ Rheumatism
Y N Sleep Apnea
Y N Sinus Problems
Y N Stomach Problems/Ulcers
Y N Psychiatric Problems
Y N HIV / Aids/ ARC
Y N Mitral Valve Prolapse
Y N Tuberculosis TB
Y N Cancer/ Tumors
Y N Difficulty Breathing
Y N Diabetes/Hypoglycemia
Y N High / Low Blood Pressure
Y N Emphysema
Y N Thyroid Problems
Y N Sickle Cell Anemia
Y N Frequent Headaches
Y N Rheumatic Fever
Y N Cosmetic Surgery
Y N Respiratory Problems
Y N Alcohol/Drug Abuse
Y N Chemotherapy
Y N Asthma
Y N Chest Pains
Y N Leukemia
Y N Abnormal Bleeding
Y N Artificial Bones/Joints
Y N Nervousness

I understand that the information that I have given today is correct and to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.
This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover.

_____

Signature Date