Thomas B. Braun, D.D.S., M.S., P.C. (Periodontal & Implant Dentistry)
2312 Plainfield Rd Crest Hill, IL 60403 (815) 744-7175)

Medical History Form

Referred By________________________________ Date _______________ E-Mail Address_______________________

Name ____ Home Phone ( )_______________________________
Last First Middle

Address____ Business Phone ( )____________________________

Cell Phone ( ) ______________________________

City __________________________________ State __________ Zip Code___________________

Employer______________________________ Job Title________________________SS#________-_______-________

Date of Birth ______/______/______ Sex M F Height_______________ Weight________________
Mo Day Yr

Name of Spouse ____________________Closest Relative______________________Phone ( ) ____________________

If you are completing this form for another person, your relationship to that person is?___________________________

Your answers to the following questions are for our records only and are considered confidential. You may be questioned during your visit on your response to the questions you answered.

1. Are you in Good health? Yes No
2. Have there been changes in your general health in the past year? Yes No
3. Physician(s) name and address ______________________________________
____
____
4. Last Physical Exam _______/______/______ Did you have blood drawn at this physical? Yes No
Mo. Day Yr.
5. Are you now under the care of your physician? Yes No
If so what is the condition being treated? ______________________________________
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?
____
7. List any medications – prescription or non-prescription that you are currently taking:
____
____
____
8. Are you on Aspirin Therapy? Yes No
9. Are you on Vitamin E Therapy? Yes No
10. Have you taken or are you taking Bizphosphanates (Fosamax, Actonel, Boniva, Didronel)? If yes please list which one(s) ____
How long have you been taking? ____________

Do you have or had any of the following diseases or problems:

1. Damages or artificial heart valves? Yes No
2. Heart murmur or rheumatic heart disease? Yes No
3. Cardiovascular disease (heart trouble, heart attack, angina, coronary, insufficiency, coronary occlusion, high blood pressure, stroke or arteriosclerosis?) Yes No
4. Chest pain upon exertion? Yes No
5. Shortness of breath after mild exercise or when lying down? Yes No
6. Do you have inborn heart defects? Yes No
7. Cardiac pacemaker? Yes No
8. Seasonal Allergies? Yes No
9. Sinus trouble? Yes No
10. Asthma or hay fever? Yes No
11. Fainting or seizures? Yes No

(Over)

12. Persistent diarrhea or weight loss? Yes No
13. Diabetes? Yes No Controlled? Yes No Blood Sugar Level: __________ Date: _________________
14. Hepatitis, Jaundice, or liver disease? Yes No
15. Aids or HIV infection? Yes No
16. Thyroid problems? Yes No
17. Respiratory problems, emphysema, bronchitis etc? Yes No
18. Arthritis or painful swollen joints? Yes No
19. Stomach ulcer or hyperacidity? Yes No
20. Kidney trouble? Yes No
21. Tuberculosis? Yes No
22. Persistent cough, cough that produces blood or persistent swollen glands in neck? Yes No
23. Low blood pressure? Yes No
24. Sexually transmitted disease? Yes No
25. Epilepsy? Yes No
26. Problems with mental health? Yes No
27. Cancer? Yes No What Type? _______________________ Treatment Received? _________________________
28. Problems of the immune system? Yes No
29. Abnormal bleeding? Yes No
30. Blood transfusion? Yes No
31. Blood disorder such as anemia? Yes No
32. Any treatment for tumor or growth? Yes No

Are you allergic or have you had a reaction to:

1. Latex Allergy? Yes No
2. Local anesthetic? Yes No
3. Penicillin or other antibiotics? Yes No
4. Sulfa drugs? Yes No
5. Barbiturates, sedatives, or sleeping pills? Yes No
6. Aspirin? Yes No
7. Iodine? Yes No
8. Codeine or other narcotics? Yes No
9. Other? ____

General Information

1. Do you have any disease, conditions, or problems not listed above you think I should know about? Yes No
   Explain: ____
2. Are you wearing contact lenses? Yes No
3. Are you wearing removable dental appliances? Yes No

Women

1. Are you pregnant? Yes No
2. Are you nursing? Yes No
3. Are you taking birth control pills? Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

____
Signature of Patient

For completion by dentist:

Comments on patient interview concerning medical history ____________________________________

____

Date: ____________________________ **Signature of Dentist:**________________________________