Richmond Surgical Arts, Inc.

Gregory T. Lynam, M.D., D.D.S.

Patient Information Sheet

HISTORY & PHYSICAL

PATIENT NAME:______________________________ DATE: ______________

IF YOUR CONDIATION IS DUE TO ACCIDENT:

When it happened?______________________ Where it happened: ______________

Describe: ____

MEDICAL HISTORY

LUNGS	YES	NO
Born with Lung Disease	( )	( )
Bronchitis	( )	( )
Asthma	( )	( )
Emphysema	( )	( )
COPD	( )	( )
Do you smoke?	( )	( )
Have you ever smoked?	( )	( )
Other (if yes, please explain)	( )	( )

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HEART	YES	NO
Born with any heart disease	( )	( )
Heart Murmur	( )	( )
Rheumatic Fever	( )	( )
High Blood Pressure	( )	( )
Irregular heart beat	( )	( )
Chest pain	( )	( )
Heart Attack	( )	( )
Heart Failure	( )	( )
Hardening of Arteries	( )	( )
High cholesterol	( )	( )
Other	( )	( )

BLOOD	YES	NO
Bruises Easily	( )	( )
Blood Clots	( )	( )
Pulmonary Embolism	( )	( )
On Blood Thinners	( )	( )
Sickle cell trait or disease	( )	( )

LIVER	YES	NO
Jaundice	( )	( )
Have you had hepatitis?	( )	( )
Drink alcoholic beverages	( )	( )
Occasionally ( )	Frequently	( )
Other liver disease	( )	( )

KIDNEY	YES	NO
	( )	( )
Kidney stones	( )	( )
Kidney Infection	( )	( )
Kidney Failure	( )	( )
Other	( )	( )

ENDOCRINE	YES	NO
Diabetes (Blood Sugar)	( )	( )
Thyroid Disorder	( )	( )
Metabolic Disorder	( )	( )
Other	( )	( )

→ How Much ______________ Per Day

→ When did you quit? ______________

NERVOUS SYSTEM	YES	NO
Epilepsy	( )	( )
Stroke	( )	( )
Neuropsychiatric Disorder	( )	( )

Eye	YES	NO
Obstructed field of Vision	( )	( )
Glaucoma	( )	( )
Contact Lenses	( )	( )
Dryness and/or burning	( )	( )

INTESTIONAL	YES	NO
Colon Disease	( )	( )
Ulcers	( )	( )
Gall Bladder Disease	( )	( )
Liver Problems	( )	( )
Other	( )	( )

REPRODUCTIVE	YES	NO
Are you pregnant?	( )	( )
History of breast disease	( )	( )
Do you have breast implants	( )	( )
Date of last mammogram	______________	
Are you attempting to become pregnant?	( )	( )

CANCER OR BENGIN TUMORS	YES	NO
Skin	( )	( )
Breast	( )	( )
Lung	( )	( )
Uterus	( )	( )
Ovary	( )	( )
Colon	( )	( )
Thyroid	( )	( )
Other	( )	( )
Radiation	( )	( )
Chemotherapy	( )	( )

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IF YOU HAVE ANY MEDICAL PROBLEMS NOT INCLUDED ON THIS CHECKLIST, PLEASE EXPLAIN

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SKIN	Yes	NO
Do you have a history of Fever Blisters?	( )	( )
Do you have a history of scarring or poor wound healing?	( )	( )
Have you had a chemical peel previously?	( )	( )

If so, what type? TCA ( ) Glycolic ( ) Other ( )

Do you have a history of any skin disorders? If yes, please list: __________________________

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SURGICAL HISTORY:

LIST PREVIOUS OPERATIONS AND APPROXIMATES DATES: ________________________

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Did you have complications after surgery?	( ) YES	( ) NO
Bleeding or blood clot?	( )	( )
Infection?	( )	( )
Keloids or thick scars?	( )	( )

ANESTHETIC HISTORY:

Allergy to any Drug used in dental work, anesthesia or surgery?	( )	( )
Any blood relative have an allergy to any drug used in surgery?	( )	( )
Any problems resulting from any local or general anesthetic ever give to you?	( )	( )

If you checked YES, please explain: ____________________________________

LIST ALL PRESENT MEDICATIONS (By name and reason for taking them)
Especially important are: Cortisone, hormones or birth control pills, aspirin or aspirin containing medications, heart medication, water pills (diuretics), tranquilizers, sedatives or antidepressants, blood thinners (or anticoagulants).
Attach list if needed: ____

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DO YOU HAVE ANY DRUG ALLERGIES? If so, please list: ________________________

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WHO IS YOUR MEDICAL DOCTOR? (First and last name please): ____________________

Address and phone: ____

PATIENT'S SIGNATURE: ______________________________________

(If patient is a minor, parent or legal guardian signature) Date: ____________________