Richmond Surgical Arts, Inc.

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

Patient Information Sheet
History & Physical

NAME: _____ DATE: _____

MEDICAL HISTORY

LUNGS	YES	NO
Born with lung disease	☐	☐
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Do you smoke?	☐	☐
If yes, how many per day? _____		
Have you ever smoked?	☐	☐
If yes, when did you quit? _____		
Other lung issues	☐	☐

If yes, please explain: _____

_____

HEART		
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 heart issues	☐	☐

If yes, please explain: _____

_____

BLOOD		
Bruises easily	☐	☐
Blood clots	☐	☐
Pulmonary Embolism	☐	☐
On blood thinners	☐	☐
Sickle Cell trait or disease	☐	☐
Other blood issues	☐	☐

If yes, please explain: _____

_____

LIVER		
Jaundice	☐	☐
Have you had hepatitis?	☐	☐
Drink alcoholic beverages	☐	☐
If yes, how often? _____		
Other liver issues	☐	☐

If yes, please explain: _____

_____

KIDNEY		
Kidney stones	☐	☐
Kidney infection	☐	☐
Kidney failure	☐	☐
Other kidney issues	☐	☐

If yes, please explain: _____

_____

ENDOCRINE	YES	NO
Diabetes [Blood Sugar]	☐	☐
Thyroid Disorder	☐	☐
Metabolic Disorder	☐	☐
Other endocrine issues	☐	☐

If yes, please explain: _____

_____

NERVOUS SYSTEM		
Epilepsy	☐	☐
Stroke	☐	☐
Neuropsychiatric Disorder	☐	☐
Other nervous system issues	☐	☐

If yes, please explain: _____

_____

EYE		
Obstructed field of vision	☐	☐
Glaucoma	☐	☐
Contact lenses	☐	☐
Dryness and/or burning	☐	☐
Other eye issues	☐	☐

If yes, please explain: _____

_____

INTESTINAL		
Colon Disease	☐	☐
Ulcers	☐	☐
Gall Bladder disease	☐	☐
Liver problems	☐	☐
Other intestinal issues	☐	☐

If yes, please explain: _____

_____

REPRODUCTIVE		
Are you pregnant?	☐	☐
History of breast disease?	☐	☐
Do you have breast implants?	☐	☐
Date of last mammogram _____		
Are you attempting to become pregnant?	☐	☐

CANCER OR BENIGN TUMORS		
Skin	☐	☐
Breast	☐	☐
Lung	☐	☐
Uterus	☐	☐
Ovary	☐	☐
Colon	☐	☐
Thyroid	☐	☐
Radiation	☐	☐
Chemotherapy	☐	☐
Other cancer/tumor issues	☐	☐

If yes, please explain: _____

_____

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

_____

_____

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 yes, which type? ☐TCA ☐GLYCOLIC ☐OTHER		
Do you have a history of any skin disorders?	☐	☐

If yes, please explain: _____

_____

SURGICAL HISTORY

LIST PREVIOUS OPERATIONS AND APPROXIMATE DATES: _____

_____

_____

Did you have complications after surgery?	☐	☐
Bleeding or blood clots?	☐	☐
Infection?	☐	☐
Keloids or thick scars?	☐	☐

ANESTHETIC HISTORY

Allergy to any drug used in dental work, anesthesia, or surgery?	☐	☐
Any blood relative have any allergy to any drug used in surgery?	☐	☐
Any problems resulting from any local or general anesthetic ever given to you?	☐	☐

If you checked YES for any of the above, please explain: _____

_____

_____

LIST ALL PRESENT MEDICATIONS [Please include the medication name and reason for taking it.] Especially important to note are the following: Cortisone, hormones or birth control pills, aspirin or aspirin-containing medications, heart medication, water pills [diuretics], tranquilizers, sedatives or anti-depressants, blood thinners [or anticoagulants]. Attach list if needed. _____

_____

_____

_____

_____

DO YOU HAVE ANY DRUG ALLERGIES? ☐YES ☐NO If yes, please list: _____

_____

_____

WHO IS YOUR PRIMARY CARE/REFERRING DOCTOR? [First and last name please]: _____

Address and phone number: _____

_____

PATIENT'S SIGNATURE: _____

[If patient is a minor, parent/legal guardian's signature]

DATE: _____