Patient Name: _____ Date: _____

RYAN DENTAL Group

MEDICAL HISTORY

What is your medical doctor's name, address, and phone number?
Name: _____ Phone Number: _____
Address: _____ State_____ Zip_____
Do you see any specialists? Yes No If yes, give name and specialty: _____
Date of your last physical examination: _____ Reason: _____

Circle Yes or No to the following and give dates and explanations as necessary

Y N	hospitalization for illness or injury	**Y N**	artificial joints (hip, knee, etc.)
Y N	chest pain	**Y N**	arthritis (osteo or rheumatoid)
Y N	heart surgery, disease, attack	**Y N**	glaucoma
Y N	heart murmur	**Y N**	contact lenses
Y N	artificial heart valves	**Y N**	epilepsy, convulsions, seizures
Y N	pacemaker	**Y N**	fainting/dizzy spells
Y N	atrial fibrillation	**Y N**	head injury
Y N	high blood pressure	**Y N**	venereal disease
Y N	low blood pressure	**Y N**	hepatitis (Type A, B, C)
Y N	high cholesterol	**Y N**	lumps/swelling in the mouth, neck, throat
Y N	stroke	**Y N**	cancer / non-cancerous tumors
Y N	anemia or other blood disorder	**Y N**	radiation therapy / chemotherapy
Y N	prolonged bleeding	**Y N**	immune problems/immunocompromised
Y N	COPD / emphysema	**Y N**	HIV/AIDS
Y N	tuberculosis	**Y N**	handicap (mental / physical)
Y N	asthma	**Y N**	psychiatric treatment
Y N	sleep apnea / snoring	**Y N**	antidepressant medication
Y N	kidney disease	**Y N**	anti-anxiety medication
Y N	liver disease/jaundice	**Y N**	prescription sleeping pills
Y N	thyroid or parathyroid disease	**Y N**	alcohol/drug dependency
Y N	hormone deficiency	**Y N**	cortisone medication
Y N	diabetes (Type I or II)	**Y N**	blood thinner medication
Y N	hypoglycemia	**Y N**	bone loss prevention meds(Actonel/Boniva/Fosamax/Etc.)
Y N	stomach or duodenal ulcer / reflux	**Y N**	history or current use of tobacco (smoke / smokeless)
Y N	digestive disorders	**Y N**	FEMALE taking birth control pills
Y N	hives, skin rashes	**Y N**	FEMALE pregnant or lactating

ALLERGIES Circle any of the following that you have had an allergic reaction to:

No Allergies Penicillin Erythromycin Aspirin Ibuprofen Acetaminophen

Codeine Latex Tetracycline Local Anesthetic Fluoride Metals

Other Allergies: _____

Have you ever been told by a doctor that you should take a pre-medication prior to dental treatment? Yes No
If yes, who advised pre-medication? (doctor's name) _____
What is the reason for the pre-medication? _____

Please describe any current medical treatment, impending surgery, or other treatment that you feel may possibly effect your dental treatment: _____

_____

List all medications you are currently taking, including drug <u>name</u>, <u>dose</u>, and <u>reason</u> you take the medication:

_____

_____

If you have extensive medical conditions, medications, allergies, or anything else you feel we need to know and don't have room in the blanks above, please provide a separate list with a date on it that we can attach to this form .
AT EACH APPOINTMENT, BE PREPARED TO PROVIDE AN UPDATED LIST OF ALL OF YOUR MEDICATIONS. ALSO, PLEASE ADVISE US OF ANY CHANGES TO YOUR MEDICAL HISTORY.

Patient/Guardian Signature _____ **Date** _____
Doctor Remarks:

Doctor's Signature_____**Date**_____