Ryan T. Beelman D.M.D
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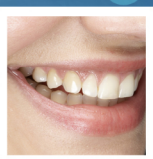

Medical History

Physician Name:

Phone:

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Other
- [ ] Allergies-Seasonal
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Hayfever
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Allergy- Tetanus
- [ ] Allergy-Lactose
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Ht.Valves
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Blood Transfusion
- [ ] Cancer
- [ ] Cardio Disease
- [ ] Diabetes type 1 or 2
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Excessive Urination
- [ ] Fainting
- [ ] GERD
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Jaundice
- [ ] Joint replacement
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Migraines
- [ ] Mouth ulcers
- [ ] Multiple Sclerosis
- [ ] Nervous Disorders
- [ ] NeurologicalDisorder
- [ ] Osteoporosis
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Sleep Disorder
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Thyroid
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Do you have any allergies?

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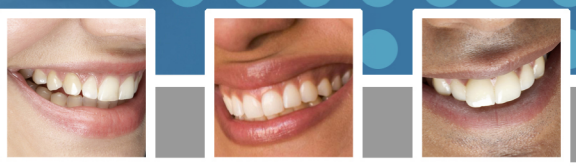

List your current medications

*

Have you had a serious illness, operation or been hospitalized in the past 5 years?

◯ Yes ◯ No

If yes, what was the illness or problem?

Joint Replacement: have you had an orthopedic total joint (hip,knee,elbow,finger) replacement?

* ◯ Yes ◯ No

If so when

*

Do you take or are scheduled to receive an antiresorptive agent (Ex: Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

* ◯ Yes ◯ No

Do you use tobacco products?

◯ Yes ◯ No

Do you drink alcohol?

◯ Yes ◯ No

Women Only:

Are you pregnant?

* ◯ Yes ◯ No

Number of weeks?

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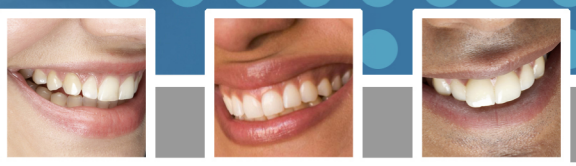

Taking Birth control pills or Hormonal replacement?

* ◯ Yes ◯ No

Dental Information

What is the reason for our dental visit today?

Have you had any of the following?

- ☐ Periodontal (gum) treatments
- ☐ Dental pain or discomfort
- ☐ Neck Pains
- ☐ Mouth sores or ulcers
- ☐ Orthodontic (braces) treatments
- ☐ Earaches
- ☐ Jaw issues (clicking, popping or discomfort)
- ☐ Grinding your teeth

Do you wear dentures or partials?

◯ Yes ◯ No

How do you feel about your smile?

Patient/Legal Guardian

Signature: _____ Date: _____

Dentist

Signature: _____ Date: _____

Response Date: _____