

PATIENT MEDICAL HISTORY FORM

Name _____ Age _____ Sex M F

Referred to Practice By _____

Allergies or Asthma	Yes	No	Alcohol Abuse	Yes	No
Arthritis	Yes	No	Drug Abuse (Prescription or Illicit)	Yes	No
Bleeding Problems or Blood Disease _____	Yes	No	Smoking	Yes	No
Cancer other than skin _____	Yes	No			
Diabetes	Yes	No	Hepatitis A , B or C (circle)	Yes	No
Gastrointestinal Disease _____	Yes	No	HIV + / AIDS	Yes	No
Heart Problems or Irregular Heartbeats	Yes	No	Tuberculosis	Yes	No
High Blood Pressure	Yes	No	Sexually Transmitted Disease _____	Yes	No
Hormonal Problems	Yes	No			
Kidney Disease _____	Yes	No	Skin History		
Liver Disease _____	Yes	No	Personal or Family history of Skin Disease (e.g. eczema, psoriasis) _____	Yes	No
Lung Disease _____	Yes	No	Atypical Moles or Dysplastic Nevi	Yes	No
Psychiatric (Emotional) Problems _____	Yes	No	Skin Cancer {circle below} (Basal Cell, Squamous Cell, Melanoma)	Yes	No
Seizures, Stroke or Neurological Disorder _____	Yes	No			
Thyroid Disease	Yes	No	Family History of Skin Cancer Specify _____	Yes	No
Personal or Family history of Autoimmune disease (e.g. Lupus or Scleroderma) _____	Yes	No			

List All Other Medical Problems Not Listed Above _____

Surgical History

Allergies to Lidocaine / Novacaine (local anesthetics) or Epinephrine?	Yes	No
Do you take antibiotics before Dental Work?	Yes	No
Have an Artificial Joint or Valve, Defibulator or Pacemaker?	Yes	No
Take blood thinners (Aspirin, Coumadin or Plavix) or Bleed Excessively?	Yes	No
Heal with a thick scar (Keloid) or have poor wound healing?	Yes	No

Women

Are you Pregnant _____ or Planning Pregnancy in next 6 months?	Yes	No
Have Regular Menstrual Periods? _____	Yes	No
Take Birth Control Pills?	Yes	No

Occupation _____ Hobbies _____

Are you **ALLERGIC** to any Medications? Please List _____

List **ALL** Medications (Prescription, Over-the-counter, Vitamins, Herbals and Topicals)

I have filled this history sheet out and to the best of my knowledge have not omitted any information.

Signature of Patient (Parent or Guardian if minor) _____

Date _____

Reviewed by Physician _____ Date ____/____/____