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____/____/____