

MEDICAL INFORMATION

Please check each box if you have a personal history of ANY of the following illnesses:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Thyroid condition | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Angina/Congestive Failure | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Prostate problem | <input type="checkbox"/> Kidney problem | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Fever blisters/cold sores | <input type="checkbox"/> Herpes infection | <input type="checkbox"/> Recurrent yeast infections | <input type="checkbox"/> Colitis/ Bowel problems |
| <input type="checkbox"/> Frequent/severe headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Artificial joint / heart valve | <input type="checkbox"/> Cancer: Type/Date: _____ |
| <input type="checkbox"/> Radiation/ X- ray treatment:
Site: _____ | | <input type="checkbox"/> Past Surgery: _____ | |
| <input type="checkbox"/> Are you pregnant OR nursing now? | | | |

CURRENT HEALTH / ALLERGIES

- Do you smoke. How much? _____ Do you drink alcohol? How much? _____
- Check if you require oral antibiotics before dental work.
- Please list all known drug allergies: _____
- Please list all known food allergies: _____

DERMATOLOGIC HISTORY

Do you have or have you EVER had:

- | | | |
|---|---|--|
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Keloids/Abnormal Scars | <input type="checkbox"/> Abnormal cold sensitivity |
| <input type="checkbox"/> Poor wound healing | <input type="checkbox"/> Skin pigmentation problems | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Palpitations/irregular beat | <input type="checkbox"/> Eczema | <input type="checkbox"/> Reaction to local anesthesia: _____ |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Dysplastic Nevus | <input type="checkbox"/> Precancerous spots/ Solar keratoses |
| <input type="checkbox"/> PLEASE LIST ALL PRIOR SKIN CANCERS: (date/location): _____ | | |

FAMILY HISTORY

Do you have a family history of:

- | | | |
|--|---|--|
| <input type="checkbox"/> Basal Cell of Squamous Cell Carcinoma | <input type="checkbox"/> Malignant Melanoma | <input type="checkbox"/> Dysplastic Nevi |
| <input type="checkbox"/> Other skin disorder: What? _____ | | |

MEDICATIONS

Please list ALL current medications: _____

Date: _____ Patient Signature: _____