ESTABLISHED/NEW PATIENT MEDICAL HISTORY

Name_____Age_____Sex M F

Referred to practice by: _____

Allergies or Asthma	Yes	No	Alcohol Use	Yes	No
Arthritis	Yes	No	If yes, how many drinks per week?		
Bleeding Problems or Blood Disease_____	Yes	No	Use of Prescription or Illicit Drugs?_____	Yes	No
Cancer other than skin_____	Yes	No	Smoking	Yes	No
Diabetes	Yes	No			
Gastrointestinal (stomach problems)_____	Yes	No	Hepatitis A B or C (circle)	Yes	No
Heart Problems or Irregular Heartbeats	Yes	No	HIV+/AIDS	Yes	No
High Blood Pressure	Yes	No	Tuberculosis	Yes	No
Hormonal Problems	Yes	No	Sexually Transmitted Disease	Yes	No
Kidney Disease_____	Yes	No	If yes, what type?_____		
Lilver Disease_____	Yes	No	**Skin History**		
Lung Disease_____	Yes	No	Personal or Family history of Skin Disease	Yes	No
Psychiatric (Emotional) Problems	Yes	No	IE: (eczema, psoriasis)_____		
Seizures, Stroke or Neurological Disorder_____	Yes	No	Atypical Moles or Dysplastic Nevi	Yes	No
Thyroid Disease	Yes	No	Skin Cancer (circle below)	Yes	No
Personal or Family history of Autoimmune disease IE: (Lupus or Scleroderma)_____	Yes	No	(*Basal Cell, Squamous Cell, Melanoma)*		
			Family History of Skin Cancer	Yes	No
If yes, please circle either Personal or Family			Specify_____		

*List All Other Medical Problems Not Listed Above*_____

Surgical History

Allergies to Local Anesthetics (Lidocaine/Novacaine) or Epinephrine?	Yes	No
Do you take antibiotics before Dental Work?	Yes	No
Have an Artificial Join 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
Currently on Contraceptives?	Yes	No
Polycystic Ovarian Disease?	Yes	No

Occupation_____Hobbies_____

When you go into the sun do you (please choose one):

a) always burn, never……( ) b) usually burn tan with difficulty…….( )
c) sometimes burn, usually tan……....( ) d) rarely burn, tan easily……...( )

Are you **ALLERGIC** to many medications and/or foods? Please List_____

List **ALL** Medications (Prescription, over-the-counter, Vitamins, Herbals, and Tropical's)

_____

_____

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)

*Reviewed by Physician*_____*Date*_____