

MEDICAL INFORMATION

I. MEDICAL / SURGICAL HISTORY:

Do you have or have you EVER had:

- Yes No High blood pressure
 Yes No Diabetes
 Yes No Stomach ulcers
 Yes No Tuberculosis
 Yes No Thyroid condition: _____
 Yes No Asthma
 Yes No Hayfever / seasonal allergies: _____

 Yes No Sinus infections / problems
 Yes No Epilepsy
 Yes No Stroke or TIA
 Yes No Heart attack /Angina / Congestive Failure
 Yes No Pacemaker
 Yes No Heart murmur or Mitral valve prolapse
 Yes No Kidney / Bladder problem: _____

 Yes No Prostate problem: _____
 Yes No Glaucoma
 Yes No Hepatitis / Liver disease: _____

 Yes No Fever blisters/Cold sores/Herpes infection
 Yes No Recurrent yeast infections
 Yes No Colitis / Bowel problems: _____

 Yes No Frequent/severe Headaches OR Migraines
 Yes No Artificial joint / heart valve:
 Yes No Cancer: Type/ Date: _____

 Yes No Radiation / X-ray treatment: site _____
 Yes No Past surgery: _____

 Yes No Are you pregnant OR nursing now?

II. CURRENT HEALTH:

Circle: Poor Fair Good Excellent

- Yes No Do you smoke? How much? _____
 Yes No Do you drink alcohol? How much? _____
 Yes No Do you require oral antibiotics before dental work?

III. ALLERGIES:

PLEASE LIST ALL KNOWN DRUG ALLERGIES:

PLEASE LIST ALL KNOWN FOOD ALLERGIES:

IV. DERMATOLOGIC HISTORY:

Do you have or have you EVER had:

- Yes No Dizziness / fainting tendency
 Yes No Keloids or abnormal scarring
 Yes No Abnormal cold sensitivity
 Yes No Poor wound healing
 Yes No Skin pigmentation problems
 Yes No Bleeding tendency
 Yes No Palpitations / Irregular heartbeat
 Yes No Reaction to local anesthesia: type _____
 Yes No Eczema
 Yes No Psoriasis
 Yes No Dysplastic Nevus
 Yes No Precancerous spots/Solar keratoses

PLEASE LIST ALL PRIOR SKIN CANCERS

(date/location):

V. FAMILY HISTORY:

Do you have a family history of:

- Yes No Basal Cell or Squamous Cell Carcinoma
 Yes No Malignant Melanoma
 Yes No Dysplastic Nevi
 Yes No Other skin disorder: What?

VI. MEDICATIONS:

PLEASE LIST ALL CURRENT MEDICATIONS:

Patient Signature _____ Date _____

PHYSICIAN SIGNATURE: _____