MEDICAL INFORMATION

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

□ High blood pressure □ Diabetes □ Stomach Ulcers □ Tuberculosis

□ Thyroid condition □ Asthma □ Sinus infections □ Seasonal Allergies

□ Epilepsy □ Stroke/TIA □ Pacemaker □ Heart attack

□ Angina/Congestive Failure □ Glaucoma □Heart Murmur □ Mitral Valve Prolapse

□ Prostate problem □Kidney problem □ Bladder Problems □ Liver Disease

□ Fever blisters/cold sores □ Herpes infection □ Recurrent yeast infections □ Colitis/ Bowel problems

□ Frequent/severe headaches □ Migraines □ Artificial joint / heart valve □ Cancer: Type/Date: _____

□ Radiation/ X- ray treatment: Site:_____

□ Past Surgery: _____ _____

□ 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:

□ Dizziness/Fainting □ Keloids/Abnormal Scars □ Abnormal cold sensitivity

□ Poor wound healing □ Skin pigmentation problems □ Bleeding tendency

□ Palpitations/irregular beat □ Eczema □ Reaction to local anesthesia:_____

□ Psoriasis □ Dysplastic Nevus □ Precancerous spots/ Solar keratoses

□ PLEASE LIST ALL PRIOR SKIN CANCERS: (date/location):_____

FAMILY HISTORY

Do you have a family history of:

□ Basal Cell of Squamous Cell Carcinoma □ Malignant Melanoma □ Dysplastic Nevi

□ Other skin disorder: What? _____

MEDICATIONS

Please list ALL current medications:_____

_____

_____

Date: _____ **Patient Signature:** _____