Patient Medical History

Name:_____ Today's Date:_____
Age:_____ Referring Physician:_____
Medications (include over the counter medications & supplements):_____
_____
_____
Allergies:_____

Medical History
(Please check the following that apply)

Skin Cancer:
- o Basal cell
  *Where:*_____
  *When:*_____
- o Squamous cell
  *Where:*_____
  *When:*_____
- o Melanoma
  *Where:*_____
  *When:*_____
- o Abnormal Moles
  *Where:*_____
  *When:*_____

- o Eczema
- o Psoriasis
- o Hives
- o Hayfever /allergies/asthma
- o Transplant of kidney or other organ
- o Autoimmune disease (i.e. Lupus)
- o Hepatitis/ liver disease
- o Kidney disease
- o Arthritis
- o Diabetes
- o Bleeding Disorders
- o Stroke
- o Cancer
- o Fainting/seizures
- o Headaches
- o Heart disease/valve disease
- o Heart murmur/rheumatic fever
- o Ulcers/stomach/bowel disease
- o Vision problems
- o Thyroid disease
- o Tuberculosis
- o Previous surgeries:_____
- o Other:_____

Family History
Do you have any family history of skin cancer? YES NO
If so, what type of skin cancer?_____

Other
Do you have any of the following?
Artificial joints? YES NO
Artificial heart valves? YES NO
Latex allergy? YES NO
Pacemaker? YES NO
Hepatitis? YES NO
HIV/AIDS? YES NO

Are you:
Pregnant? YES NO
Nursing? YES NO
Taking Aspirin? YES NO
Taking Blood Thinners ? YES NO
Do you:
Take antibiotics prior to dental work? YES NO
Tobacco Use? YES NO
Alcohol Use? YES NO #Drinks/Day: ___
Recreational Drug Use? YES NO

The above information is correct to the best of my knowledge.
Signature:_____Date:_____
Parent/guardian for minors:_____Date:_____