

Dermatology Medical History

Patient: _____ Date of Birth: _____ Today's Date: _____

Primary Care Physician: _____ Pharmacy _____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, please list _____

Have you ever had a bad reaction to dental or other anesthesia? YES NO Please explain _____

Do you take antibiotics before you see your dentist? YES NO

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins and herbals)

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |

Are you currently taking any blood thinners: YES NO

Do you have or have you ever had any of the following diseases or conditions:

Skin

Skin cancer: YES NO If yes, date and what type of skin cancer _____

Problems with keloids: YES NO

Excessive bruising or bleeding: YES NO

Sun sensitivity: YES NO

Heart /Vascular

Artificial heart valve: YES NO

Pacemaker or defibrillator: YES NO

High blood pressure: YES NO

Blood clots or inflammation of the veins: YES NO

Other systems

Artificial joint: YES NO

Diabetes: YES NO

Asthma/hayfever YES NO

Thyroid abnormalities: YES NO

Kidney problems: YES NO

Liver abnormalities/Hepatitis: YES NO

HIV/AIDS: YES NO

Are you feeling well today? YES NO_ If NO, please explain _____

Women only:

Are you pregnant: YES NO Due date: _____

Are you breastfeeding: YES NO

Please list any other recent disease or surgical procedures: _____

Social History

Do you smoke? YES NO

Do you drink alcohol? YES NO If YES, _____drinks per day

Family History- please list major diseases that run in your family (including skin cancer)

Completed by: patient _____

Signed by Patient/Guardian _____

_____/_____/_____
Date