Patient Health History

Please fill out as completely as possible. Please print and make sure you sign at the end.

NAME _____

REASON FOR VISIT _____
_____

ALLERGIES TO MEDICATIONS (please include reaction)_____
_____

Are you allergic to: **Lidocaine**? Y__ N__ or **Latex**? Y__ N__

ALL CURRENT MEDICATION (Please list)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

Are you currently taking: ___Aspirin ___ Coumadin ___ Plavix

Do you take antibiotics before dental work? Y__ N__

Please list any previous surgeries: _____
_____

HEALTH HISTORY : **(Patient only) Please include both current and past problems**

	Yes	No	Explain
Skin disease / Disorders			
Skin Cancer (Type? Location?)	□	□	_____
Scars / history of keloids?	□	□	_____
Acne (teenage or adult?)	□	□	_____
Eczema	□	□	_____
Psoriasis	□	□	_____
Any other skin problem or condition	□	□	_____
Cardiovascular			
Heart attack or Angina	□	□	_____
Valve disease or murmer	□	□	_____
Hypertension (high blood pressure)	□	□	

Other	☐	☐	_____

	Yes	No	Explain
Hematologic			
Excessive bleeding when cut?	☐	☐	_____
Thrombophlebitis	☐	☐	_____
Respiratory			
Asthma	☐	☐	_____
COPD / Emphysema	☐	☐	_____
Endocrine Disease			
Diabetes (Type)	☐	☐	_____
Thyroid disease / disorder	☐	☐	_____
Neurological			
Psychiatric disease / disorder	☐	☐	_____
Anxiety (or any other emotional disorder)	☐	☐	_____
Phobias	☐	☐	_____
Seizure disorder	☐	☐	_____
General			
Fatigue	☐	☐	_____
Weight Loss/Gain	☐	☐	_____
Have you ever been diagnosed with the following:			
HIV / AIDS	☐	☐	_____
Hepatitis (Type?)	☐	☐	_____
Social History			
Tobacco Use?	☐	☐	If yes, amount? ___pack/day
Alcohol Use?	☐	☐	If yes, how often?_____
Do you live alone?	☐	☐	_____

Occupation _____

Women only: Are you pregnant? Y__ N__
Are you nursing? Y__ N__

Any other health problems that are not listed above? _____
_____

Significant family medical history including family history of skin cancer? _____
_____

Patient Signature _____ **Date** ___/___/_____
Guarantor Signature _____ **Date** ___/___/_____
(if patient under age 18 or patient unable to sign)

Practitioners Signature _____ **Date** ___/___/_____