Name_____ **Date**_____

Reason for today's visit _____ **When did it start?**_____

Referring Doctor_____ **Primary Care Doctor** _____

Previous Treatment (doctor or self)_____

Are you allergic to any medication? ☐ **Yes** ☐ **No** **If Yes, list below:**

History of Medical Problems

Yes	No		Yes	No	
☐	☐	High Blood Pressure	☐	☐	Hepatitis/Yellow jaundice
☐	☐	Emphysema	☐	☐	Epilepsy/Seizures
☐	☐	Asthma	☐	☐	Glaucoma
☐	☐	Chronic Cough	☐	☐	Alcohol or Drug Abuse. When? _____
☐	☐	Angina	☐	☐	AIDS/HIV or Exposure
☐	☐	Heart Murmur	☐	☐	Arthritis
☐	☐	Pacemaker	☐	☐	Phlebitis/Blood Clots
☐	☐	Fainting Spells	☐	☐	Artificial Joints
☐	☐	Heart Valve Surgery. Year_____	☐	☐	Have you ever had a blood transfusion?
☐	☐	Irregular Heart beat	☐	☐	Do you bleed easily?
☐	☐	Heart Attack. Year? _____	☐	☐	Any previous reaction to local anesthetic?
☐	☐	Stroke/TIA. When? _____	☐	☐	Do you smoke? How much? _____
☐	☐	Heart Bypass Surgery. Year? _____	☐	☐	Do you wear sunscreen?
☐	☐	Diabetes	☐	☐	(Women) Are you pregnant or nursing)?
☐	☐	Thyroid trouble	☐	☐	Have you been advised to take antibiotic before dental procedures?
☐	☐	Kidney Disease			
☐	☐	Cancer. What kind? When? _____			

How many flights of stairs can you climb without resting? (circle) 0-1 1-2 2-3 4 or more

List surgical procedures in the last 6 months: _____

List any other significant diseases or conditions we should know about: _____

_____

What skin problems have you had in the past?_____

_____

Circle any of the following supplements or medications that you take:

ASPIRIN Vitamin E Gingko Biloba Ginseng Ephedra Garlic Feverfew Ginger

List names of all **medications** you are currently taking (prescriptions, vitamins, herbs, over the counter)

Does anyone in family have: Skin Cancer Lots of Moles Hay Fever Asthma Dry Skin

I consent to having photographs taken. These will be used only to document my care/condition and for teaching.

Patient Signature_____ Reviewed _____/_____/_____