Name_______________________________ Date of Birth_______________ Date _________________

Occupation____________________________ Reason for Visit ________________________________
Primary Care Doctor____

ALLERGIES: ____

Allergy to LATEX: YES NO

MEDICATIONS (including over-the-counter, vitamins, herbal supplements)
____

____

Is there a family history of skin cancer? YES NO TYPE: ______________________________

PATIENT MEDICAL HSTORY - CHECK ALL THAT APPLY:

SKIN CANCER: Basal Cell___________ Squamous Cell ____________ Melanoma _________________

HEART: High Blood Pressure_________ Heart Attack_________ Artificial Valves/MVP_______________
Irregular Heart Beat__________ Pacemaker _______ Defibrillator _______ Heart Murmur ___________
Bypass or Open Heart Surgery ________Heart Failure _________ High Cholesterol _________________
Other _________________
LUNG: Asthma______________ Emphysema_______________ Other_____________________________

PSYCHIATRIC: Anxiety__________ Depression ________ Bipolar Disorder________ Other____________

BLOOD: Bleeding problems ________Easily Bruise ________Anemia __________Other______________

MUSCLE/BONES: Arthritis_______ Joint Replacement_________ Other__________________________

INFECTIOUS DISEASE: HIV _________ Hepatitis ________ Tuberculosis ______ Other ______________

GENITOURINARY: Kidney Disease _______ Dialysis __________ Other___________________________

STOMACH: Ulcer_______ Reflux ______ Irritable Bowel ______ Other ___________________________

NEUROLOGICAL: Seizure ______ Stroke _______ Migraine ________ Other _______________________

ENDOCRINE: Diabetes _______ Thyroid _______ Other ____

EYES: Glaucoma ________ Cataracts _______ Other ____

EARS: Decreased Hearing ________ Hearing Aids _______ Other ________________________________
CANCER (PLEASE SPECIFY): ____
PREVIOUS SURGERY (please specify): ____
Do you smoke? YES NO How much? ______________packs per day
Former smoker? YES NO Check if never a smoker _______________
Do you drink alcohol? YES NO How much? _________________________
FEMALES: Are you pregnant or nursing? YES NO
Do you take ANTIBIOTICS before dental work? YES NO

PRESCRIPTION & PHARMACY INFORMATION

Pharmacy Name ___________________________*Pharmacy Phone*_______________________

*Pharmacy Address*____