Patient: _____ Date: ____/___/_____

Reason for today's visit:_____

Are you allergic to any medications? YES_____ NO_____

What medications? _____ What kind of reactions _____

Have you ever had dental anesthesia (Novocaine)? YES_____ NO_____ Any bad reactions? YES_____ NO_____

List all medications you are currently taking (prescriptions, over the counter meds, vitamins) with dose:

1._____2._____3._____4._____

5._____6._____7._____8._____

9._____10._____11._____12._____

Do you now or have you ever had diseases or conditions of: (Please CIRCLE yes or no)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Anxiety : | YES | NO | Pacemaker/Defibrillator: | YES | NO | History of Basal Cell: | YES | NO |
| Arthritis: | YES | NO | Atrial Fibrillation: | YES | NO | History of Squamous Cell: | YES | NO |
| Asthma: | YES | NO | Coronary Artery Disease: | YES | NO | History of Melanoma: | YES | NO |
| COPD: | YES | NO | Heart Attack: | YES | NO | Precancerous moles: | YES | NO |
| Depression: | YES | NO | High Blood Pressure: | YES | NO | Actinic Keratoses: | YES | NO |
| Diabetes: | YES | NO | High Cholesterol: | YES | NO | Blistering sunburns: | YES | NO |
| Renal Disease: | YES | NO | Blood Clots: | YES | NO | Dry skin: | YES | NO |
| Thyroid disease: | YES | NO | Blood thinners: | YES | NO | Eczema: | YES | NO |
| Hepatitis: | YES | NO | Problems with bleeding: | YES | NO | Psoriasis: | YES | NO |
| HIV/AIDS: | YES | NO | Problems with healing: | YES | NO | Rosacea: | YES | NO |
| Headaches: | YES | NO | Problems with scarring: | YES | NO | Acne: | YES | NO |
| Fainting: | YES | NO | Latex Allergy: | YES | NO | Accutane use: | YES | NO |
| Leukemia: | YES | NO | Allergic to bandages: | YES | NO | Seborrheic Keratoses: | YES | NO |
| Lymphoma: | YES | NO | Allergic to Neosporin: | YES | NO | Varicose Veins: | YES | NO |
| Seizures: | YES | NO | Artificial Heart Valve | YES | NO | | YES | NO |
| Stroke: | YES | NO | Artificial Joint | YES | NO | **Family history** of skin cancer: | YES | NO |

History of cancer? What type and how was it treated?_____

List any other diseases or conditions?_____

List any surgeries?_____

Are you currently pregnant? YES_____NO___ Are you currently breastfeeding? YES_____NO_____ _____

Do you drink alcohol? YES_NO_____ If yes, how many drink/day?_____

Do you smoke? YES_____NO_____ If yes, how many packs/day_____

**Patient Signature:** _____**Date:**_____