

Date _____
 Patient's Name _____ Date of Birth _____ Age _____
 Referring Physician _____ Primary Care Physician _____
 Reason for today's visit _____

PLEASE CHECK ALL THAT APPLY AND PROVIDE DETAILS AND DATES _____

No Pertinent Past Medical History

ALLERGIES

IMMUNIZATIONS

- Shingles vaccine
 - Pneumonia vaccine
 - Flu vaccine
 - Other Immunizations _____
- Details: _____

NEUROLOGIC

- Neuropathy
 - Deep brain stimulator (date/contact info)
 - Stroke/TIA (date)
 - Dementia/Alzheimer's
 - Hearing impaired
 - Other Neurologic _____
- Details: _____

HEART - CARDIAC

- Heart disease (date)
 - Prior heart attack (date)
 - Congestive heart failure (date)
 - Valve replacement (date)
 - Abnormal valve/Heart murmur
 - Irregular heart beat (circle: A fib, PSVT, other)
 - High blood pressure
 - High cholesterol
 - Other Cardiac _____
- Details: _____

ENDOCRINE

- Thyroid disorder: (circle: hypo or hyper)
 - Diabetes
 - Other Endocrine _____
- Details: _____

LUNGS - PULMONARY

- Asthma
 - COPD (Emphysema)
 - Sarcoidosis
 - Other Pulmonary _____
- Details: _____

GI - GASTROINTESTINAL

- Peptic ulcers
 - Hepatitis (circle type: A, B, C)
 - Liver disease
 - Inflammatory bowel disease (circle type: Crohns, UC)
 - GERD (Reflux)
 - Other GI _____
- Details: _____

PSYCHOLOGICAL

- Depression
 - Anxiety
 - Other Psychological _____
- Details: _____

URINARY SYSTEM

- Kidney disease
 - Enlarged prostate
 - Other Urinary _____
- Details: _____

MUSCLES/RHEUMATOLOGIC

- Arthritis (circle type: Osteo, Psoriatic, Rheumatoid, unknown)
 - Autoimmune disease (circle: Lupus, Sjogren's Rheumatoid Arthritis)
 - Raynaud's
 - Other Rheumatologic _____
- Details: _____

IMMUNE SYSTEM

- Seasonal allergies
 - Transplant (circle: kidney, heart, liver)
 - HIV/AIDS
 - Blood problems (circle: anemia, bleeding disorder)
 - Other Immunologic _____
- Details: _____

INFECTIOUS DISEASES

- Cold sores (Herpes)
 - Tuberculosis and/or positive PPD
 - Other Infectious _____
- Details: _____

No Pertinent Past Medical History

CANCER: Include diagnosis, treatment & year

- Breast
 - Colon
 - Leukemia, Lymphoma (type) _____
 - Lung
 - Other _____
- Details: _____

GYNECOLOGIC - GYN

- Irregular menses
 - Currently pregnant
 - Currently breast feeding
 - Planning future pregnancy
 - Other GYN _____
- Details: _____

VASCULAR DISEASE

- Blood clots (circle: legs, other _____)
- Details: _____

SKIN

- No significant skin history
 - Acne or Rosacea
 - Atypical moles
 - Eczema
 - Psoriasis
 - Keloids or Hypertrophic (thick) scars
 - Sensitive skin
 - Tanning bed use (how often?) _____
 - Other Skin _____
- Details: _____
- _____
- _____
- _____

SKIN CANCERS: Include treatment & year

- Basal cell carcinoma
 - Squamous cell carcinoma
 - Malignant melanoma
 - Other Skin Cancer _____
- Details: _____
- _____
- _____
- _____
- _____

PRIOR TREATMENTS FOR PRE-CANCERS OF THE SKIN

(circle: Solaraze, Aldara, Zyclara, Carac, Flouroplex, Efudex, Picato, PDT, Chemical Peels, Laser Resurfacing)

- Other Treatments _____

Details: _____

SURGERIES: Include year

- Cardiac (Heart)
 - Joint replacement (circle: knee, hip, other/year)
 - Tonsillectomy
 - Gallbladder
 - Vein stripping
 - Tubal ligation
 - Hysterectomy
 - Cataract
 - Cosmetic
 - Other Surgeries _____
- Details: _____

PACEMAKER/DEFIBRILLATOR

- Not applicable
 - Pacemaker (copy card)
 - Defibrillator (copy card)
 - Pacemaker/Defibrillator combo
 - Cardiologist and date
- Details: _____

FAMILY HISTORY (Skin cancers or skin conditions)

- Family history unknown - Adopted
 - No family history of skin conditions
 - Atypical moles
 - Malignant Melanoma (Skin cancer)
 - Skin cancers (SCC, BCC)
 - Severe acne
 - Autoimmune disorders
 - Psoriasis
 - Eczema
 - Other Pertinent Family History _____
- Details: _____

SOCIAL HISTORY

Do you use alcohol? Yes No
If Yes: Socially Intermittent Daily

Do you use illegal drugs? Yes No
If Yes, please explain: _____

Tobacco use: Never Former smoker
 Current usage: number of packs/day? _____

Occupation _____

Do you live alone? Yes No

Hobbies _____

**MEDICATIONS: Name of drug, dosage and frequency
Including Vitamins, Over-the-Counter Drugs, Herbal Remedies**

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

Do you take any blood thinners? Yes No
(Circle) Vitamin E, Plavix, Coumadin, Other _____

Do you take any NSAIDS? Yes No
(Circle) ibuprofen, naprosyn, aspirin, other _____

Do you need to take antibiotics prior to dental work? Yes No