PATIENT HISTORY FORM

Date: _____/_____/_____ *Please Circle:* New Patient Return Visit

Name: ______________________________ DOB: ______/______/__________

Gender: ____________________ Occupation: ______________________________

Referring Physician: ______________________________

Reason for todays visit: ______________________________

____

Duration: ____________ Has your current skin condition ever itched (please circle)? Y N

Has your current skin condition ever bled (please circle)? Y N

Have you tried medications or had treatment in the past for your current condition? If so, please list:

____

Family History – Check if any blood relative has:

Allergies	( )	Asthma	( )	Arthritis	( )
Eczema	( )	Diabetes	( )	Heart Disease	( )
Hay Fever	( )	Skin Cancer	( )	Hypertension	( )
Hives	( )	Malignant Melanoma	( )	Tuberculosis	( )
Psoriasis	( )	Other Cancer	( )	None	( )

Personal Past Medical History or Current Disease of:

	Yes	No		Yes	No
Headache/Seizure	( )	( )	Hepatitis C (or liver disease)	( )	( )
Psychiatric	( )	( )	HIV/AIDS	( )	( )
Eyes/Ears/Nose/Throat/Mouth	( )	( )	Blood/Bleeding disorders	( )	( )
Lungs	( )	( )	Heart Attack	( )	( )
Stomach/Bowels	( )	( )	Stroke	( )	( )
Kidney Disease	( )	( )	High Blood Pressure	( )	( )
Rheumatologic	( )	( )	Heart Disease/Murmur/Rhythm	( )	( )
Allergic/Immunologic	( )	( )	Artificial Heart Valve	( )	( )
Organ Transplant	( )	( )	Artificial Joint	( )	( )
Blistering Sunburn	( )	( )	Diabetes or Thyroid Disease	( )	( )
Melanoma	( )	( )	Radiation Therapy	( )	( )
Skin Disorder (incl. cancer)	( )	( )	Pacemaker/Defibrillator	( )	( )

If you answered yes to any above, please explain: ______________________________

Other major medical illnesses/surgeries: ______________________________

Allergies (drug, food, pet): ______________________________

Do you take antibiotics prior to seeing a dentist? If yes, explain: ______________________________

Current Medications (include aspirin, vitamin E, herbs, and non-prescription): ______________________________

____

Do you use alcohol? ________ /week Do you Smoke? _________ packs/day

Do you have a history of substance abuse? ______________________________

Have you ever used tanning booths? ______________________________

PATIENT SIGNATURE: ______________________________ Date: ______/______/__________