



## Patient Medical Information

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**PLEASE PROVIDE THE FOLLOWING INFORMATION:**

1. Please list all known drug allergies. \_\_\_\_\_
2. Please list all medications you are currently taking. \_\_\_\_\_  
\_\_\_\_\_
3. Have you ever had any operations? Yes No If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_

4. Have you ever been treated for any of the following (**please circle Yes or No for each, if Yes, please explain**):

- |  |     |    |  |
|--|-----|----|--|
| a. Constitutional Symptoms<br><i>(weight loss/gain, fever, etc.)</i> | Yes | No |  |
| b. Eye Disorders   | Yes | No |  |
| c. Ear, Nose, Throat, and Mouth                                      | Yes | No |  |
| d. Respiratory Disorders (lung disease)                              | Yes | No |  |
| e. Digestive Diseases  | Yes | No |  |
| f. Urinary/Bladder/Kidney Disease                                    | Yes | No |  |
| g. Blood Disorders   | Yes | No |  |
| h. Muscle/Skeletal Disorders   | Yes | No |  |
| i. Skin Disorders  | Yes | No |  |
| j. Neurologic Disorders  | Yes | No |  |
| k. Psychiatric   | Yes | No |  |
| l. Endocrine (diabetes, thyroid, etc.)                               | Yes | No |  |
| m. Cardiovascular<br><i>(high blood pressure, heart disease)</i>     | Yes | No |  |
| n. Cancer  | Yes | No |  |
| o. Allergic/Immunologic  | Yes | No |  |
| p. Scarring (keloids, etc.)  | Yes | No |  |
| q. Hepatitis or HIV  | Yes | No |  |

5. Do you routinely *require antibiotics prior* to dental/surgical procedures due to a heart murmur, artificial heart valve, artificial joint, etc.? Yes No
  
6. Do you take an anticoagulant, such as Coumadin, Plavix, or Aspirin (please circle if applicable)? Yes No
7. Do you smoke or chew Tobacco? Yes No / Do you drink Alcohol? Yes No
8. Do you have a history of Skin cancer? Yes No / Do you have a Family history of Skin cancer? Yes No
9. Do you have a history of Skin disease? Yes No / Do you have a Family history of Skin disease? Yes No

**10. FOR WOMEN ONLY:**

- a. Are you pregnant or currently planning a pregnancy? Yes No
- b. Are you currently nursing? Yes No