MEDICAL HISTORY

Patient Name _______________ Today's Date _______________

Primary Insurance Company _______________ Employer _______________

Referring Doctor _______________

Are you pregnant? Y N
Are you trying to become pregnant? Y N
Are you nursing? Y N

DOB _______________

Please list all allergies	Please list all medications you take
	(Dosage, Frequency, Route)

Do You Have or Have You Had Any of the Following:

Mitral Valve Prolapse Y N	Rheumatic Fever Y N
Do you need antibiotics prior to having dental work. Y N	Epilepsy, Seizures, Fainting Spells Y N
Heart Murmur Y N	High Blood Pressure Y N
Pacemaker Y N	Heart Attack Y N
Heart disease Y N	Abnormal Bleeding/Hemophilia Y N
Asthma Y N Hay Fever Y N	Skin Allergies Y N
Arthritis Y N	HIV/Aids Y N
Kidney Disease Y N	Hepatitis ABC Y N
Thyroid Disease Y N	Liver Disease Y N
Drug/Alcohol dependency Y N	Diabetes Y N
Cancer Y N If yes, what type?	Glaucoma Y N
Personal History of Skin Cancer Y N If yes, what type?	Specific Skin Diseases Y N If yes, what type?
Do you smoke? Y N Number of packs per day	Family History of Skin Cancer Y N If yes, what type? Which relative?
Do you drink alcohol ? Y N Number of drinks per week	Do you have any pain today related to your skin ? Y N Where? How long ?
	Have you ever had a Pneumococcal vaccination ? Y N