THE DERMATOLOGY CLINIC

Patient Name: _____ Date: _____
Occupation: _____ Birthdate: _____
Reason for today's visit: _____
Are you allergic to any medications? ☐ Yes ■ No
If yes, list: _____
Have you ever had a reaction to dental or local anesthesia (novocaine)?
☐ Yes ☐ No If yes, describe reaction: _____
Do you take antibiotics before you go to the dentist?
☐ Yes ☐ No If yes, why? _____
Do you have a pacemaker or implanted defibrillator? ☐ Yes ☐ No
If female, are you pregnant or nursing? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No How much? _____
List all medication that you regularly take, including prescriptions, over the counter meds, vitamins and herbal supplements: _____

Do **you** now have, or have you ever had the following diseases or conditions? (Please check yes or no)

Skin Cancer	☐ Yes ☐ No	If yes, list:	_____
Family history of skin cancer	☐ Yes ☐ No	If yes, list:	_____
Specific skin conditions	☐ Yes ☐ No	If yes, list:	_____
Cold sores	☐ Yes ☐ No	If yes, how frequently?	_____

High Blood Pressure	☐ Yes	■ No	Emphysema	☐ Yes	■ No
Heart attack	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No	Chronic cough	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Irregular heartbeat	☐ Yes	☐ No	Wheezing	☐ Yes	☐ No
Artificial heart valve	☐ Yes	☐ No	Blood Clots	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Seasonal allergies	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No	Bleeding disorder	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Gastrointestinal disease	☐ Yes	☐ No
Epilepsy/seizure	☐ Yes	☐ No	Liver disease/Hepatitis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Artificial joints	☐ Yes	☐ No
Mental illness	☐ Yes	☐ No	HIV	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No			

List any other conditions/major surgeries: _____

Completed by: ☐ Patient
☐ Family member

_____
Patient Signature **Date**