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

Please list all allergies	Please list all medications you take

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	Liver Disease Y N
Thyroid Disease Y N	Diabetes Y N
Drug/Alcohol Dependency Y N	Glaucoma Y N
Cancer Y N If yes, what type	Specific Skin Diseases Y N If yes, what type?
Personal History of Skin Cancer Y N If yes, what type?	Family History of Skin Cancer Y N if yes, what type? Which Relative?
Do you smoke Y N Number of packs per day	Do you drink alcohol Y N Number of drinks per week

Doctor's Comments _____

1. Date _____ Comments _____ Initials _____
2. Date _____ Comments _____ Initials _____
3. Date _____ Comments _____ Initials _____