| Name | Date of Birth | Appointment Date |  |
| --- | --- | --- | --- |
| Primary Care Physician (PCP)  *Name*  *Address (if known)*  *Phone Number (if known)* | Medications |  | Allergies to Medications |
| Do you take blood thinners (Coumadin/Warfarin, aspirin, Plavix, etc? Yes No If yes, please list. |  |  | Do you take antibiotics before going to the dentist?  Yes No If yes, why? |

Medical History

| Yes No | High Blood Pressure | Please list other Medical Problems. |
| --- | --- | --- |
| Yes No | Pacemaker |  |
| Yes No | Artificial Heart Valve |  |
| Yes No | Bleeding Disorders |  |
| Yes No | Liver Disease |  |
| Yes No | Artificial Joint/Prosthetic |  |
| Yes No | Diabetes |  |
| Yes No | Asthma |  |
| Yes No | Hay Fever |  |
| Yes No | Keloids |  |

Family History/Social History

|  Is there a family history of...? If yes, who? |  |  | Other Family Diseases | Hobbies | Occupation |
| --- | --- | --- | --- | --- | --- |
| Yes No | Skin Cancer |  |  |  |  |
| Yes No | Melanoma |  |  |  |  |
| Yes No | Psoriasis |  |  |  |  |
| Yes No | Eczema |  |  | Do you smoke?  Yes No | Do you drink regularly?  Yes No |
| Yes No | Vitiligo |  |  |  |  |

Review of Systems

|  Do you currently have issues/symptoms with your…? |  | If yes, please describe. |
| --- | --- | --- |
| Skin (Other than primary reason for visit) | Yes No |  |
| General Health | Yes No |  |
| Eyes | Yes No |  |
| Ears/Nose/Mouth/Throat | Yes No |  |
| Heart | Yes No |  |
| Liver | Yes No |  |
| Lungs | Yes No |  |
| Stomach/Bowel | Yes No |  |
| Kidneys | Yes No |  |
| Headaches/Seizures | Yes No |  |
| Psychological | Yes No |  |
| Thyroid/Diabetes | Yes No |  |
| Blood/Bleeding Disorder | Yes No |  |
| Females: Are you pregnant? | Yes No |  |

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Patient Signature Date