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HEALTH HISTORY

Name		Age		Date	
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My general health is: Good Fair Poor

YES **NO** Do you currently have, or have you had in the past:

___ ___ Drug allergies or adverse reactions to drugs (local anesthetics, antibiotics, analgesics or other drugs? Please specify: _____

___ ___ Other allergies? (plants, hay fever, insects, asthma) _____

___ ___ High blood pressure, heart disease, or heart murmur? Are you prone to faint after an injection or other procedure?

___ ___ Recurrent infections or poor healing?

___ ___ Tendency to bleed, especially after surgery or tooth extraction?

___ ___ Recent illness or infection?

___ ___ Tuberculosis, hepatitis, AIDS, or other chronic infections?

___ ___ Cancer?

___ ___ Osteoporosis, bone, or joint disease?

___ ___ Diabetes, high or low blood sugar, sugar in the urine, duodenal or peptic ulcer?

___ ___ Do you bruise easily?

___ ___ Are you currently taking any medications? If yes, please list:

___ ___ Are there any medications which you cannot take or are not supposed to take? If yes, please list: _____

___ ___ Are you currently being treated for any other condition?

- ____ ____ Have you ever been hospitalized or ever had surgery?
- ____ ____ Do you smoke? If so, how many packs per day? _____
- ____ ____ Do you drink? If so, what is your average alcohol consumption per week?

- ____ ____ WOMEN ONLY – Are you pregnant? When was your last menstrual period?

SKIN HISTORY:

- ____ ____ Melanoma, basal cell or squamous cell carcinoma? Any family history of skin cancer?
Please specify type: _____
- ____ ____ Warts (facial or other), cold sores, fever blisters or herpes simplex? Any family member
with the same?
- ____ ____ Unusual mole changes or “spots on the skin” which concerns you?
- ____ ____ Treatment for acne? Accutane or other forms?
- ____ ____ Vitiligo (loss of normal color of skin) or increase of pigmentation?
- ____ ____ Lax skin, double jointedness or joint discoloration?
- ____ ____ Abnormal scarring, keloids or painful scars?
- ____ ____ Cosmetic surgery?
- ____ ____ Psoriasis, eczema, hives or dermatitis?
- ____ ____ X-ray therapy, radiation treatment?
- ____ ____ Are there any other skin diseases, conditions, allergies or illnesses which you have but
were not mentioned before?
- ____ ____ Have you ever had the need to see a psychiatrist, psychologist, or psychiatric social
worker?
- ____ ____ Do you use sunscreens?

Family/Personal physician _____

Signed _____ Date _____

Signature of patient or persons authorized to give consent. Please state your relationship.

Relationship _____