

Town Square Dermatology Medical History Form

Patient: _____ 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list: _____
Family history of skin cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list: _____
Specific skin conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list: _____
Cold sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how frequently? _____

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

List any other conditions/major surgeries: _____

Completed by: Patient
 Family member

Patient Signature **Date**

Read and reviewed with the patient. _____

Provider's Signature *Date*