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	☐ 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
If yes, list_____		Liver disease/Hepatitis	☐ Yes ☐ No
Epilepsy/seizure	☐ Yes ☐ No	Artificial joints	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	HIV	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No

List any other conditions/major surgeries:_____
_____

Are you currently experiencing?

Problems with bleeding	☐ Yes ☐ No	Problems with scarring/keloids	☐ Yes ☐ No
Fever or chills	☐ Yes ☐ No	Night sweats	☐ Yes ☐ No
Unintentional weight loss	☐ Yes ☐ No	Joint Pain	☐ Yes ☐ No

Completed by: ☐ Patient
☐ Family member

_____
Patient Signature **Date**

Read and reviewed with the patient. _____
Provider's Signature *Date*

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