

MEDICAL HISTORY

Do you have a history of:

- Skin Cancer?
- Pre - skin cancer (actinic Keratosis)?
- Unusual (atypical) moles?
- Herpes cold sores (fever blisters)?
- Xeloid (hypertrophic) scars?
- Severe sunburns?

NO	YES	COMMENT
		Type?

Do you tan easily?

Do you use tanning booths?

Do you wear sunscreen?

Do you have a history of:

- High blood pressure?
- Pacemaker?
- Artificial heart valves?
- Angina?
- Heart Attack (MI)?
- Taking a blood thinner?

NO	YES	COMMENT

Do you have or have you had a history of:

- Asthma?
- Seasonal allergies?
- COPD or emphysema?

Do you require supplemental oxygen?

NO	YES	COMMENT

Do you have or have you had a history of:

- Acid reflux or heart burn?
- Crohn's disease or ulcerative colitis?
- Ulcers?

NO	YES	COMMENT

Do you have:

- Diabetes?
- Thyroid disease
- HIV or AIDS?

Do you require antibiotics prior to dental surgery?

Do you have problems with local anesthetics?

NO	YES	COMMENT
		high or low

FAMILY HISTORY

Do you have a family member with:

- Melanoma?
- Unusual (atypical) moles?
- Seasonal allergies or asthma?

NO	YES	COMMENT
		Who?
		Who?

PLEASE LIST PREVIOUS SURGERIES _____

PLEASE LIST ALL MEDICATIONS _____

FOR WOMEN OF CHILD BEARING AGE:

Are you pregnant or think you might be pregnant?

Do you use birth control?

Are your menstrual periods regular?

Date of last menstrual period _____

NO	YES	COMMENT
		Weeks:
		Type:

Signed (Patient or Legal Guardian) _____

Date _____

Reviewed: _____
