

Name: _____ Age: _____
Last First M.I.

Are you allergic to any medications? Yes ___ No ___ If Yes, please list: _____

Primary Doctor: (Name & Address) _____

Referred by: Doctor ___ Friend ___ Relative ___ Other ___

Are you taking birth control pills? Yes ___ No ___ Type _____

Have you ever had a severe sunburn? Yes ___ No ___

Do you have a pacemaker? Yes ___ No ___ Name of Pharmacy: _____

Do you have a prescription reimbursement plan? Y ___ N ___ Phone: _____ Address: _____

Do you take antibiotics before a dental procedure? Y ___ N ___

Medical Problems, please list:	Prescription Medications, please list	Over the Counter Medications, please list: (Pain Relief, Laxatives, Vitamins, Herbs)
1 _____	1 _____	1 _____
2 _____	2 _____	2 _____
3 _____	3 _____	3 _____
4 _____	4 _____	4 _____
5 _____	5 _____	

REVIEW OF SYSTEMS

(Constitutional)

___ weight loss ___ night sweats
___ fevers ___ fatigue

(Eyes)

___ cataracts ___ glaucoma
___ blurry vision

(Ears)

___ ringing in ears ___ hearing loss

(Cardiovascular)

___ heart disease ___ chest pain
___ heart murmur
___ high blood pressure

(Respiratory)

___ shortness of breath ___ sinusitis
___ tuberculosis ___ cough
___ hay fever ___ asthma

(Gastrointestinal)

___ abdominal pain ___ bloody stool
___ jaundice ___ hepatitis ___ ulcer

(Genitourinary)

___ frequent urination
___ sexually transmitted disease

(Musculoskeletal)

___ joint pain ___ lupus
___ muscle weakness

(Skin)

___ eczema ___ abnormal mole
___ psoriasis ___ difficulty healing
___ itching ___ hives
___ bruise easily ___ hair loss
___ keloids ___ lupus
___ frequent sun exposure
___ skin cancer; type _____

(Neurologic)

___ seizures ___ headaches
___ dizziness

(Endocrine)

___ diabetes ___ thyroid disease

(Heme)

___ anemia ___ excessive bleeding

(Cancer)

type _____

SOCIAL HISTORY

Do you smoke? Yes ___ No ___

If yes, how many packs per week _____

Do you drink alcohol? Yes ___ No ___

If yes, how many drinks per day _____,
per week _____

Occupation _____

List Other (Please explain): _____

List Past Surgeries: _____

FAMILY HISTORY - PLEASE EXPLAIN IF ANYONE IN YOUR FAMILY HAS HAD ANY OF THE FOLLOWING:

Description/Relation (Mother, Father, etc.)

Skin Cancer, type: (basal cell, squamous cell, melanoma, don't know) _____

Other Skin Disorders (Psoriasis, Eczema, etc.) _____

Reviewed by :

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In the event of an emergency please notify: Name _____ Phone # (____) _____

Relationship _____ Date _____

