Patient Medical Information

Patient Name_____ Patient DOB _____

Family History

Has anyone in your family ever had any of the following? (please check all that apply)

- ○ Diabetes
- ○ Psoriasis
- ○ Melanoma
- ○ Systemic lupus erythematosus
- ○ Vitiligo
- ○ Nonmelanoma skin cancer
- ○ Scleroderma
- ○ Asthma, eczema, or hives

Patient Social History

Use of Alcohol	○ Never	○ Occasional	○ Moderate	○ Previous/quit_____
Use of Tobacco	○ Never	○ Occasional	○ Moderate	○ Previous/quit_____
Use of Recreational Drugs	○ Never	○ Occasional	○ Moderate	○ Previous/quit_____

Patient Medical History

Please check below if you have ever had or currently have any of the following (check all that apply)

- ○ Allergies to medications *
- ○ Allergy to local anesthesia
- ○ Heart disease or high blood pressure
- ○ Pacemaker
- ○ Antibiotics before dental procedures
- ○ Lung disease or emphysema
- ○ Asthma or hay fever
- ○ Sinus problems or allergies
- ○ Seizures or headaches
- ○ Fainting spells
- ○ Emotional or psychiatric problems
- ○ Digestive problems or ulcers
- ○ Medical anti-aging treatment injections
- ○ Liver disease or hepatitis
- ○ Arthritis
- ○ Joint replacements
- ○ Kidney problems
- ○ Problems with eyesight
- ○ Anemia or bleeding problems
- ○ Diabetes (specify type)

_____Type 1 _____Type 2

- ○ Thyroid disease
- ○ Diagnosis of HIV or AIDS
- ○ Chronic skin conditions
- ○ Eczema or atopic dermatitis
- ○ Skin cancer
- ○ Vitiligo
- ○ Abnormal moles
- ○ Melanoma
- ○ History of keloids or thick scars
- ○ X-ray or Grenz ray treatments

*If you marked “yes” to having any Allergies to medications, please list: _____

The following questions are for female patients only.

Do you have polycystic ovaries?	○ Yes	○ No	Do you take oral contraceptives (OCCs)?	○ Yes	○ No
Do you have menstrual periods?	○ Yes	○ No	Do OCCs make your skin uneven?	○ Yes	○ No
If so, are your periods regular?	○ Yes	○ No	Are you on hormone treatments?	○ Yes	○ No
Are you pregnant?	○ Yes	○ No	Do you have new facial hair growth?	○ Yes	○ No
Are you planning a pregnancy?	○ Yes	○ No	Do you have recurring/frequent yeast infections?	○ Yes	○ No

Please list all medications you are taking, including vitamins, laxatives, pain relievers, and herbal remedies.

Please list any surgical procedures you have had.

Please list any other medical conditions or problems you may have that were not addressed above.

Patient or Guardian Signature

Date