

Patient Name: _____ Date of Birth: _____ Date: _____
Last First Middle

Pharmacy Address: _____ Pharmacy Phone #: _____ Fax: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Reason for Visit: New Patient Current Patient Follow Up for: _____
 Rash Lesion(s) Routine Full Skin Exam

#1: Onset: _____ Location(s): _____ Treatment: _____

#2: Onset: _____ Location(s): _____ Treatment: _____

MEDICAL HISTORY: (conditions for which you are followed by a physician or hospitalized in the past)

Check Here if NO Medical Conditions

SKIN (normal)

- Skin Cancer: type _____
- Eczema
- Acne: Prior treatment _____
- Psoriasis/Psoriatic Arthritis
- Herpes: Oral Genital
- Shingles: Date _____
- Staph infection/MRSA
- Keloids
- Accutane: Year _____
- UV Light Treatments
- Abnormal Scars
- OTHER _____
- OTHER _____

CARDIOVASCULAR (normal)

- Pacemaker/AICD
- Heart Murmur: Type _____
- Rheumatic Heart Disease
- Artificial Heart Valve
- High Blood Pressure
- Heart Attack
- Coronary Artery Disease
- Stents/Angioplasty _____
- Irregular Heart Rhythm
- Peripheral Vascular Disease
- High Cholesterol
- OTHER _____
- OTHER _____

PULMONARY (normal)

- Asthma
- Seasonal Allergies/Hay fever
- COPD/Emphysema
- Pulmonary Embolism
- Sleep Apnea/CPAP mask

HEMATOLOGIC (normal)

- Anemia _____
- Bleeding Disorder
- Blood clots (legs)
- Leukemia/Lymphoma

ENDOCRINE (normal)

- Diabetes
- Thyroid Disease
- OTHER _____

MUSCULOSKELETAL (normal)

- Artificial Joints Date: _____
- Arthritis: Type _____

GASTROINTESTINAL (normal)

- Acid Reflux/GERD
- Celiac Disease/Sprue
- Hepatitis: Type: _____
- Ulcerative Colitis/Crohn's
- Stomach Ulcer/Peptic Ulcer
- Liver/Gall Bladder Disease
- OTHER _____
- OTHER _____

IMMUNE/INFECTIOUS/CANCER (normal)

- Cancer _____
- Radiation Treatments
- Chemotherapy
- Organ Transplant
- HIV/AIDS
- Tuberculosis: Date _____
- Lupus
- Other immune disorder

PSYCHIATRIC (normal)

- Depression/Other Psychiatric
- Anxiety

NEUROLOGIC (normal)

- Migraines
- Stroke
- Seizures
- Alzheimer's
- Multiple Sclerosis

OTHER (normal)

- Pregnant/Nursing (currently)
- Glaucoma/Cataracts
- Kidney Disease/Dialysis
- Kidney Stones
- Gout
- Prone to Yeast Infections
- Planning pregnancy
- OTHER _____
- OTHER _____

SURGICAL HISTORY: Type/Date: _____

DO YOU TAKE ANTIBIOTICS BEFORE DENTAL WORK? YES NO

Why? Joint Replacement Heart Murmur Heart Valve Replacement Other

ALLERGIES: NONE Tetracyclines Penicillin Sulfa Codeine Latex
 Tape/Band-Aids Lidocane Polysporin/Neosporin Betadine/Iodine Shellfish

OTHERS: _____

MEDICATIONS: Include DOSE and other over-the-counter, vitamins, herbals: NONE

<input type="checkbox"/> Aspirin mg	<input type="checkbox"/> Coumadin mg	<input type="checkbox"/> Plavix mg	<input type="checkbox"/> Pradaxa mg
<input type="checkbox"/> Antacids	<input type="checkbox"/> Birth Control	<input type="checkbox"/> Ibuprofen/NSAIDs	<input type="checkbox"/> Prednisone mg
1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.

FAMILY HISTORY: NONE

<input type="checkbox"/> Skin Cancer: type	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Abnormal Moles	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Eczema	<input type="checkbox"/> Cancer	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Crohn's
<input type="checkbox"/> Celiac Sprue	<input type="checkbox"/> Dermatitis Herpetiformis	<input type="checkbox"/> Allergies	<input type="checkbox"/> Asthma
<input type="checkbox"/> Neurofibromatosis	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Neurologic Disease	<input type="checkbox"/> OTHER

HOBBIES: _____

SMOKING: Current Smoker/How Much? _____ Former Smoker (have stopped) Never

DRINKING: YES/How Much _____ NO **ILLICIT DRUG USE:** YES NO

CURRENT OR PAST PROBLEMS WITH: (Review of Systems) NONE

<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Cough	<input type="checkbox"/> Short of Breath	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Difficulty Urinating
<input type="checkbox"/> Pain with Urination	<input type="checkbox"/> Weakness	<input type="checkbox"/> Muscle Aches	<input type="checkbox"/> Joint Aches	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Stiff Neck	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Pain in Skin	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Vision Changes	<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> OTHER

Signature: _____ **Medical Personnel:** _____ **Date:** _____

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