Patient Health Information Form

Name_____Date_____

*Please state the reason for your visit today:*_____

*Please list all Allergies to medication:*_____

*Please list all the medications you take including aspirin and vitamins:*_____

_____

_____

*Circle any of the following conditions which you have had or been treated for:*_____

Stomach or intestinal problems	Liver or gall bladder disease, hepatitis
Lung diseases (COPD, TB, asthma)	Heart disease, Rheumatic fever
High blood pressure	Stroke, Heart attack
Kidney disease	Blood disorder
HIV	Diabetes
Eye disease (glaucoma, corneal transplant)	Arthritis, Lupus, Joint replacement
Cancer (type)_____	Neurological disorder (MS, other)

Do you smoke? YES NO

Do you have a pacemaker or defibrillator? YES NO

Do you take antibiotics before routine dental procedures? YES NO

Is there a history of skin cancer in your family? YES NO (melanoma, BCC, SCC)

Have you previously had a skin problem? YES NO
If yes, please describe:_____

Prior Hospitalizations and Surgery (give dates)_____

For Women (circle):

Are you Pregnant? YES /NO Are you Breast Feeding? YES /NO Taking Birth control? YES /NO

Please inform the doctor if you plan to become pregnant or become pregnant during treatment.

X_____
Patient or Guardian's Signature Date