



PATIENT HEALTH HISTORY

Patient Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Check all current or past medical conditions:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Problem Scarring | <input type="checkbox"/> Depression Disorder | <input type="checkbox"/> Unusual Moles |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke | <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Thyroid Disease | Type: _____ |
| <input type="checkbox"/> TIA | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Current Pregnancy | <input type="checkbox"/> Angina/Chest Pain | Type: _____ |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Ulcers/Keloids | <input type="checkbox"/> Other: _____ |

Do you need to take antibiotics prior to surgery or dental procedures? Yes No

List all current medications and dosages: _____

List all drug allergies: _____

List all past surgeries: _____

Do you smoke or use tobacco? Yes No How much do you use daily? _____

Are you a past smoker or tobacco user? Yes No When did you quit? _____

Do you consume alcohol? Yes No How much do you consume daily? _____

Are you a past alcohol user? Yes No When did you quit? _____

Have any close relatives had any of the following?

- Melanoma Head or neck cancer Skin cancer other than melanoma Unusual mole

What is the nature of your visit? _____

I have read this questionnaire and answered the questions to the best of my knowledge. I am responsible to notify the office and the physician if any changes occur in my medical condition. If I fail to keep the doctor informed on my full medical history, I may be at an increased risk for complications or unexpected results from the planned treatments.

Patient Signature: _____ Date: _____

(Signature of a parent or legal guardian is required for patients under the age of 18 years.)