MEDICAL HISTORY

Do you have a history of:	NO	YES	COMMENT
Skin Cancer?			Type?
Pre - skin cancer (actinic Keratosis)?			
Unusual (atypical) moles?			
Herpes cold sores (fever blisters)?			
Xeloid (hypertrophic) scars?			
Severe sunburns?			
Do you tan easily?			
Do you use tanning booths?			
Do you wear sunscreen?			

Do you have a history of:	NO	YES	COMMENT
High blood pressure?			
Pacemaker?			
Artificial heart valves?			
Angina?			
Heart Attack (MI)?			
Taking a blood thinner?			

Do you have or have you had a history of:	NO	YES	COMMENT
Asthma?			
Seasonal allergies?			
COPD or emphysema?			
Do you require supplemental oxygen?			

Do you have or have you had a history of:	NO	YES	COMMENT
Acid reflux or heart burn?			
Crohn's disease or ulcerative colitis?			
Ulcers?			

Do you have:	NO	YES	COMMENT
Diabetes?			
Thyroid disease			high or low
HIV or AIDS?			
Do you require antibiotics prior to dental surgery?			
Do you have problems with local anesthetics?			

FAMILY HISTORY

Do you have a family member with:	NO	YES	COMMENT
Melanoma?			Who?
Unusual (atypical) moles?			Who?
Seasonal allergies or asthma?			

PLEASE LIST PREVIOUS SURGERIES________________________________

PLEASE LIST ALL MEDICATIONS________________________________

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FOR WOMEN OF CHILD BEARING AGE:	NO	YES	COMMENT
Are you pregnant or think you might be pregnant?			Weeks:
Do you use birth control?			Type:
Are your menstrual periods regular?			

Date of last menstrual period____________________

Signed (Patient or Legal Guardian)________________________________ Date____________________

Reviewed: ____________________ ____________________ ____________________

____________________ ____________________ ____________________