Name	Date of Birth	Appointment Date

Primary Care Physician (PCP) *Name* *Address (if known)* *Phone Number (if known)*	Medications	Allergies to Medications
Do you take blood thinners (Coumadin/Warfarin, aspirin, Plavix, etc? ☐Yes ☐No If yes, please list.		Do you take antibiotics before going to the dentist? ☐Yes ☐No If yes, why?

Medical History

☐Yes ☐No	High Blood Pressure	Please list other Medical Problems.
☐Yes ☐No	Pacemaker	
☐Yes ☐No	Artificial Heart Valve	
☐Yes ☐No	Bleeding Disorders	
☐Yes ☐No	Liver Disease	
☐Yes ☐No	Artificial Joint/Prosthetic	
☐Yes ☐No	Diabetes	
☐Yes ☐No	Asthma	
☐Yes ☐No	Hay Fever	
☐Yes ☐No	Keloids	

Family History/Social History

• Is there a family history of...? If yes, who?			Other Family Diseases	Hobbies	Occupation
☐Yes ☐No	Skin Cancer				
☐Yes ☐No	Melanoma				
☐Yes ☐No	Psoriasis				
☐Yes ☐No	Eczema			Do you smoke? ☐Yes ☐No	Do you drink regularly? ☐Yes ☐No
☐Yes ☐No	Vitiligo				

Review of Systems

• Do you currently have issues/symptoms with your…?		If yes, please describe.
Skin (Other than primary reason for visit)	☐Yes ☐No	
General Health	☐Yes ☐No	
Eyes	☐Yes ☐No	
Ears/Nose/Mouth/Throat	☐Yes ☐No	
Heart	☐Yes ☐No	
Liver	☐Yes ☐No	
Lungs	☐Yes ☐No	
Stomach/Bowel	☐Yes ☐No	
Kidneys	☐Yes ☐No	
Headaches/Seizures	☐Yes ☐No	
Psychological	☐Yes ☐No	
Thyroid/Diabetes	☐Yes ☐No	
Blood/Bleeding Disorder	☐Yes ☐No	
Females: Are you pregnant?	☐Yes ☐No	

_____	_____	_____	_____
Patient Signature	Date	Provider Signature	Date