

**MEDICAL HISTORY**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Primary Insurance Company

\_\_\_\_\_  
Occupation

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Referring Doctor

Please list all allergies, including food.		Please list all medications you take, including over the counter.		
Allergy	Reaction	Medication	When you take it	Dosage (mg)

ARE YOU PREGNANT? _____	ARE YOU TRYING TO BECOME PREGNANT? _____
ARE YOU NURSING? _____	DO YOU HAVE A LATEX ALLERGY? _____
DO YOU HAVE AN ADHESIVE ALLERGY?, I.E. Tape, bandages, etc. _____	
DO YOU HAVE A SHELL FISH ALLERGY? _____	

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:**

Disease/Disorder	Yes	No	Disease/Disorder	Yes	No
Diseases of the Skin If yes, what type?			High Blood Pressure		
Personal History of Skin Cancer If yes, what type?			Heart Attack		
Family History of Skin Cancer If yes, what type?			Cancer If yes, what type?		
Abnormal bleeding or Hemophilia			Rheumatic Fever		
Do you need antibiotics prior to dental work? If yes, what type?			Epilepsy, Seizures, Fainting Spells		
Heart Murmur			HIV/Aids		
Pacemaker			Glaucoma		
Heart Disease			Do you smoke If yes, number of packs per day?		
Kidney Disease			Do you drink alcohol Number of drinks per week?		
Thyroid Disease			Skin Allergies		
Asthma			Diabetes		