

Patient Name: _____ Date of Birth ____/____/____

MEDICAL HISTORY

Chart No. _____

Do you have a personal history of **ANY** of the following: (*check YES or NO*)

Diabetes	YES	NO	Positive TB Test	YES	NO
High Blood Pressure	YES	NO	If YES, were you treated?	YES	NO
Heart Disease	YES	NO	Glaucoma	YES	NO
If YES, explain _____			Pacemaker	YES	NO
Lung Disease	YES	NO	Implanted Defibrillator	YES	NO
Arthritis	YES	NO	Artificial Heart Valve	YES	NO
Kidney Disease	YES	NO	Liver Disease	YES	NO
Hepatitis	YES	NO	Artificial Joint	YES	NO
If YES, explain _____			Bleeding Disorder	YES	NO
Tobacco Use	YES	NO	Alcohol Use	YES	NO
Drug/Narcotic Habit	YES	NO	HIV Infection	YES	NO
Cancer (other than skin)	YES	NO	Diagnosed With HIV	YES	NO
Type: _____					

Are you Immunosuppressed? Do you take chemotherapy, prednisone, steroids, or medications to prevent the rejection of a transplant? YES NO

Do you have side affects from taking antibiotics such as nausea, yeast infections, or vomiting? YES NO

List any other significant illnesses, family histories of skin cancer, or prior surgeries:

Do you have a personal history of skin cancer? YES NO

If yes, please explain when, what type & where: _____

List ALL medications you are presently taking. Include aspirin or any over-the-counter medications:

List medication allergies (including Latex) YES NO: _____

Patient Signature: _____ **Date:** ____/____/____

_____/_____/_____ **Patient Signature:** _____ **Today's Date** ____/____/____

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