

NEW PATIENT HISTORY SHEET

NAME: _____ AGE: _____ SEX: _____

HEALTH HISTORY

Have you ever had:

- | | | | |
|--------------------------------|--|-----------------------------------|--|
| Allergies—Hay fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcohol Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Aneurysm | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease: Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lupus Erythematosus | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you Wear a Prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Brain Tumor | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: _____ | |
| Cataracts / Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psoriasis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataract Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric or emotional Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scleroderma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty Breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures or neurological disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eczema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gastrointestinal | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack or Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Substance Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hormonal Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Urinary Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Immune Deficiency – HIV Tested | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Irregular Heart | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Do you Premedicate before:		Recent Hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental work	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Novacaine or Lidocaine	<input type="checkbox"/> Yes <input type="checkbox"/> No		

1) Are you allergic to any foods or drugs? Yes No

Please List: _____

2) What Prescriptions or Medications Do You Take?: _____

3) What Nonprescription Medications (over the counter) such as aspirin, antihistamines or laxatives are you taking? _____

4) Do you heal with a thick scar (keloid) Yes No

5) Poor Wound healing Yes No

Note: The Dermatological Examination which you are to receive is not a complete physical examination. It is suggested that you have a complete exam periodically by your family physician or internist.

Signature of Patient _____ Date _____

Signature of Parent or Guardian if Patient is a Minor _____ Date _____