Patient History

- **SKIN CANCER**
  Yes No
  Type:
  Basal Cell Carcinoma
  Squamous Cell Carcinoma
  Malignant Melanoma
- **OTHER TYPES OF SKIN CANCER**
  Yes No
  Type_____
  _____
- **HISTORY OF HEART PROBLEMS**
  Yes No
  Artificial Heart Valve
  Heart Murmur
  Pacemaker
  Defibrillator
- **BLEEDING DISORDERS**
  Yes No
  Type: _____
- **HISTORY OF BLOOD TRANSFUSIONS**
  Yes No
- **HIGH BLOOD PRESSURE**
  Yes No
- **ARTHRITIS**
  Yes No
- **ARTIFICIAL JOINTS**
  Yes No
  Type: _____
- **NEUROLOGICAL DISEASE**
  Yes No
  Type: _____
- **HEADACHES**
  Yes No
  Type: _____
- **PSYCHIATRIC HISTORY**
  Depression: Yes No
  Other: _____
- **AUTO-IMMUNE DISEASE**
  Yes No
  Type: _____
  Lupus
  Rheumatoid Arthritis
- **EYE DISEASE**
  Yes No
  Type: _____
  Glaucoma
  Cataracts
- **SEASONAL ALLERGIES**
  Yes No
- **ENDOCRINE DISEASE**
  Yes No
  Type: _____
  Diabetes
  Thyroid Problem
- **HAVE YOU EVER HAD X-RAY TREATMENT FOR ACNE?**
  Yes No

******WOMEN ONLY******

- **OB/GYN**
  Breast Feeding Yes No
  Pregnant Yes No
  Planning Pregnancy Yes No

- **HIV/AIDS**
  Yes No
- **LIVER DISEASE**
  Yes No
  Type_____
  Hepatitis B Yes No
  Hepatitis C Yes No
- **FAMILY HISTORY OF SKIN CANCER**
  Yes No
  Type_____
  _____
- **FAMILY HISTORY OF MEDICAL PROBLEMS**
  Yes No
  Type:_____
  _____
- **SOCIAL HISTORY**
  Smoke
  Yes- packs per day_____
  No
  Alcohol
  Yes-drinks per week_____
  No
- **SEXUALLY TRANSMITTED DISEASE**
  Yes No
  Type: _____
- **ILLICIT DRUGS**
  Yes No
  Type: _____
- **OTHER MEDICAL PROBLEMS**
  Yes No
  Type:_____
  _____
  _____
- **SURGICAL HISTORY**
  List:_____
  _____
  _____
- **HISTORY OF ACCIDENTS IN LAST 5 yrs**
  List:_____
  _____
  _____
  _____
- **HOSPITALIZATIONS IN LAST 5 yrs**
  List:_____
  _____
  _____
- **MEDICATION ALLERGIES**
  Yes No
  List:_____
  _____
  _____
- **LIST MEDICATIONS CURRENTLY TAKING**
  _____
  _____
  _____
- **HAVE YOU PREVIOUSLY TAKEN ANTIBIOTICS PRIOR TO DENTAL CLEANINGS/PROCEDURES**
  Yes No

PRINT NAME:_____

SIGNATURE:_____

DATE:_____