

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Reason for your visit today:** \_\_\_\_\_

<b>Medications:</b> <i>(Please list all prescription and over the counter vitamin, minerals, etc)</i>		
<b>Allergies to Medicines:</b> Medication / Reaction		

Do you need antibiotics prior to having dental cleanings?  Yes  No If yes, why: \_\_\_\_\_  
Have you ever had a bad reaction to dental anesthesia (ex: novocaine)?  Yes  No

**Please check YES or NO** of appropriate box of medical conditions you have had or currently are experiencing:

	Yes	No		Yes	No
Healthy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
History of Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Cosmetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>
Ears/ Nose / Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Stomach / Bowel	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Blood / Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints (if yes, year _____)	<input type="checkbox"/>	<input type="checkbox"/>	Headaches / Seizures / Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid / Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other diseases or conditions: \_\_\_\_\_

Please list major surgeries, by date, in the last 5 years: \_\_\_\_\_

Please list hospitalizations (if different than above): \_\_\_\_\_

**SKIN:** When you are exposed to sun, do you:  Burn  Tan and Burn  Tan only  
Have you ever had a **Skin Cancer**?  Yes  No If yes, which type?  Basal Cell  Squamous Cell  Melanoma  
If yes, Locations of Skin Cancers: \_\_\_\_\_  
Do you have a history of any specific skin diseases? \_\_\_\_\_

**Women ONLY:** Are you pregnant?  Yes  No  Maybe Are you on Birth Control?  Yes  No  
Are you post menopausal?  Yes  No

**Social History:** Occupation: \_\_\_\_\_ Are you exposed to chemicals/sun at work?  Yes  No  
Do you smoke?  No  Former  Yes: How many packs per day? \_\_\_\_\_  
Do you drink alcohol?  No  Former  Yes: How many drinks per day? \_\_\_\_\_

**Family History:**  Melanoma: who? \_\_\_\_\_  other cancer: \_\_\_\_\_  
 skin diseases: \_\_\_\_\_

Completed by:  patient  
 medical assistant (initials) \_\_\_\_\_  
Reviewed by:  medical assistant \_\_\_\_\_

J. Morgan O'Donoghue, MD / Cynthia Price, PA-C

Date \_\_\_\_\_