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DO YOU HAVE A HISTORY OF:
(Please check if any apply to you)

PATIENT NAME: ______________________

DATE: ______________________

- ☐ ABNORMAL BLEEDING
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ DIABETES
- ☐ DYSPLASTIC NEVUS
- ☐ ECZEMA
- ☐ HAYFEVER
- ☐ HERPES SIMPLEX (COLD SORES)
- ☐ HIV/AIDS EXPOSURE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIVES
- ☐ KELOIDS/ ABNORMAL SCARRING OR HEALING
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MELANOMA ☐ FAMILY HISTORY OF MELANOMA
- ☐ PEPTIC ULCER
- ☐ PSORIASIS
- ☐ SKIN CANCER
- ☐ TUBERCULOSIS
- ☐ HEART CONDITION: ☐ MITRAL VALVE PROLAPSE ☐ MURMUR

DO YOU USE SUNSCREEN?
☐ YES ☐ NO
TYPE OF SUNSCREEN: ______________________
SPF: ______________________

WHEN EXPOSED TO THE SUN DO YOU:

- ☐ BURN, NEVER TAN
- ☐ BURN, SOMETIMES TAN
- ☐ TAN, OCCASIONALLY BURN
- ☐ TAN, NEVER BURN

Do you have a pacemaker? ________________
Do you require antibiotics before dental work? (If so, please list) ______________________________________

Allergies ?
Drug: ______________________________________
Environmental: ______________________________________

Current skin care regimen:
Cleanser: ______________________________________
Moisturizer/Lotion: ______________________________________
Makeup: ______________________________________
Other: ______________________________________
Current Medications (Please list and include over the counter products, vitamins, herbs).
Oral: ______________________________________
Topical: ______________________________________

Any history of serious illness or surgery? ______________________________________

What is your chief concern today? ______________________________________