

DAWES FRETZIN DERMATOLOGY GROUP

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING MEDICAL CONDITIONS:

YES	NO	CARDIOVASCULAR	YES	NO	EYE
___	___	High Blood Pressure	___	___	Cataracts
___	___	Coronary Artery Disease (CHF, Heart Attack)	___	___	Glaucoma
___	___	Arrhythmia (Irregular Rhythm)	___	___	NEUROLOGIC/PSYCH
___	___	Valve Disease/Replacement	___	___	Seizures/Epilepsy
___	___	Rheumatic Fever	___	___	Stroke
___	___	PULMONARY	___	___	Migraines
___	___	Asthma/Emphysema	___	___	Depression/Anxiety/Other
___	___	Tuberculosis	___	___	ENDOCRINE
___	___	RENAL/KIDNEY	___	___	Diabetes
___	___	Renal Insufficiency	___	___	Thyroid
___	___	Dialysis	___	___	High Cholesterol
___	___	Kidney Stones	___	___	GENERAL
___	___	LIVER/GASTROINTESTINAL	___	___	Osteoporosis
___	___	Hepatitis	___	___	Arthritis (Osteo or Rheumatoid)
___	___	Cirrhosis	___	___	AIDS/HIV+
___	___	Gallstones	___	___	Sun Sensitivity
___	___	Ulcers	___	___	History of any Cancer (Other than Skin)
___	___	Ulcerative Colitis/Crohn's Disease	___	___	If YES, Form of Cancer (i.e. Lung, Breast, Colon)

PLEASE LIST ANY ADDITIONAL ITEMS:

CURRENT MEDICATIONS:

PLEASE LIST PREVIOUS SURGERIES:

ALLERGIES TO MEDICINES:

CHECK THE FOLLOWING MEDICAL CONDITIONS THAT HAVE OCCURRED IN YOUR IMMEDIATE FAMILY:

<u>DISEASE</u>	<u>SELF</u>	<u>Mother</u>	<u>Father</u>	<u>Sibling</u>	<u>NONE</u>
Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer (Non-Melanoma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you live alone? ___ Yes ___ No Occupation _____
 Do you drink alcohol? ___ Yes ___ No If yes, frequency _____ (#per day/week/month).
 Do you smoke? ___ Yes ___ No If yes, frequency _____ (#packs per day/week/month).
 Are you pregnant or planning to become pregnant? ___ Yes ___ No

Do you have a pacemaker, artificial heart valves, artificial joints, or other conditions that require antibiotic prophylaxis before a dental or surgical procedure? ___ Yes ___ No Are you allergic to any anesthetics such as lidocaine? ___ Yes ___ No

PATIENT/LEGAL GUARDIAN SIGNATURE _____

PRINT NAME _____ **UPDATES** _____

DATE _____

REVIEWED _____ **DATE:** _____
 (M.D. Signature)