FILL OUT AND SEND IN PRIOR TO APPOINTMENT

NAME: _____ DATE OF VISIT: ____/____/____ DATE OF BIRTH: ____/____/____

SYSTEM REVIEW: Check all that apply regarding your health and any other important problems

SKIN
- ☐ Abnormal scarring
- ☐ Keloids (where?_____)
- ☐ None

INFECTIONS
- ☐ Cold sores/Fever blisters/Herpes
- ☐ Hepatitis/Jaundice
- ☐ HIV/AIDS
- ☐ Tuberculosis (TB)
- ☐ Immunosuppression
- ☐ Other _____
- ☐ None

CONSTITUTIONAL SYMPTOMS
- ☐ Weight Loss
- ☐ Fever
- ☐ Dizziness or fainting
- ☐ None

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Artificial heart valve
- ☐ Arrhythmia (irregular heart beat)
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Heart Attack (when? _____)
- ☐ Other _____
- ☐ None

ENDOCRINE
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Kidney transplant
- ☐ Other
- ☐ None

GASTROINTESTINAL
- ☐ Liver Damage
- ☐ Liver transplant
- ☐ Other _____
- ☐ None

HEMATOLOGIC / LYMPHATIC
- ☐ Anemia
- ☐ Bleeding problems
- ☐ Other
- ☐ None

MUSCULOSKELETAL
- ☐ Artificial joint
- ☐ Other _____
- ☐ None

NEUROLOGICAL
- ☐ Stroke
- ☐ Seizures
- ☐ Other
- ☐ None

PSYCHIATRIC
- ☐ Anxiety attacks
- ☐ Depression
- ☐ Other_____
- ☐ None

RESPIRATORY
- ☐ Flu Vaccine
- ☐ Pneumonia Vaccine
- ☐ Asthma
- ☐ None

Do you have Advanced Directives? Yes ____ No____

PAST HISTORY

Do you take antibiotics before undergoing dental procedures? ☐ No ☐ Yes *[Prophylactic abs. ☐ indicated ☐ not indicated/or skin surgery]*

Previous skin cancer: ☐ Basal Cell ☐ Squamous Cell ☐ Melanoma ☐ None ☐ Other

X-ray treatment (not routine dental or chest x-rays)? ☐ No ☐ Yes If yes, what for? _____

Ultraviolet light treatment: ☐ Yes ☐ No If yes, ☐ Tanning Bed (UVA) ☐ UVB ☐ PUVA ☐ PDT ☐ Other _____

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF _____

Major illnesses, hospitalizations and surgeries (include year and reason): _____

_____

FAMILY HISTORY

Skin Cancer: ☐ Basal Cell ☐ Squamous cell ☐ Melanoma ☐ None ☐ Other _____

SOCIAL HISTORY

Do you wear: ☐ Contact lenses ☐ Hearing Aid | Alcohol: ☐ No ☐ Yes If yes, how much? _____

Smoking: ☐ No ☐ Former ☐ Yes, packs per day _____ ☐ Pipe ☐ Cigar ☐ Chewing Tobacco ☐ Nicotine tablets/patch

LIST MEDICATIONS DOSAGE AND FREQUENCY TAKEN

If you need more room use the reverse side.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

LIST MEDICATION ALLERGIES AND REACTIONS

☐ NO KNOWN DRUG ALLERGIES

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Have you recently traveled to West Africa or had contact with someone who has traveled to West Africa? ☐ Yes ☐ No

Ebola Risk: Fever >= 100.4 degrees (F) / 38.0 degrees (C) ☐ Yes ☐ No

Ebola Risk: Resided or Traveled To Country with wide-spread Ebola transmission in the last 21 days ☐ Yes ☐ No

Ebola Risk: Contact with an Ebola Patient without proper protective equipment in the last 21 days ☐ Yes ☐ No

Ebola Risk: Headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain, and/or hemorrhage ☐ Yes ☐ No

MEDICATION LIST