Brandon Dermatology Medical History

Patient: ______________________________________Date of Birth: ____/____/________ Age: ___________

(Last) (First) (M.I.) Male ☐ Female ☐

Personal History: (please check all appropriate boxes)

Arthritis/Joint Pain Yes ☐ No ☐
Artificial joint Yes ☐ No ☐
Cancer Yes ☐ No ☐
If yes, type: ______________________
Depression Yes ☐ No ☐
Multiple Sclerosis Yes ☐ No ☐
Thyroid Disease Yes ☐ No ☐
Kidney Disease Yes ☐ No ☐
Chron's/Colitis Yes ☐ No ☐
Liver Disease Yes ☐ No ☐
Gastric Ulcers Yes ☐ No ☐

Pacemaker Yes ☐ No ☐
Defibrillator Yes ☐ No ☐
Heart valve surgery Yes ☐ No ☐
High blood pressure Yes ☐ No ☐
Bleeding disorder Yes ☐ No ☐
Hepatitis Yes ☐ No ☐
AIDS/HIV Yes ☐ No ☐
Herpes/cold sores Yes ☐ No ☐
Tuberculosis Yes ☐ No ☐

Skin disease Yes ☐ No ☐
If yes, please list: _________________
____

Skin cancer Yes ☐ No ☐
Keloids Yes ☐ No ☐

Other____
Medication prior to dental cleaning/procedures Yes ☐ No ☐

Family History:
Has anyone in your family had skin cancer? Yes ☐ No ☐ If yes, what type: ____

Medications: (please list ALL medicines including aspirin, birth control pills, vitamins/supplements, diet pills)
____
____
____

Allergies to Medications: Yes ☐ No ☐ (please list)
____
____

Surgery: (list all) ____

Social History:
Do you smoke? Yes ☐ No ☐
Do you use snuff/smokeless tobacco? Yes ☐ No ☐

Occupation: ___________________Employer:_____________________

Women: (Please Complete)
First day of last menstrual cycle: ___________
Pregnant: Yes ☐ No ☐
Breast-feeding: Yes ☐ No ☐

How did you hear about our practice: __________________________ Referred by: ____

I acknowledge that I have completed the above information to the best of my ability.

Patient Name: __________________ Patient Signature____________________________ Date: ___________