

Name: _____ SS# _____ Date: _____ M _____ F _____

Have you ever had any of the following: (If yes, please explain)

- Reactions or allergies to local anesthetics such as those used by a dentist? YES NO
 - Bleeding disorders, frequent nosebleeds, easy bruising or bleeding longer than most people when cut? YES NO
 - Have you ever fainted? YES NO
 - Do cuts on your skin heal with normal scars? YES NO
 - Are you allergic or have you had a "bad reaction" to any substances applied to your skin? YES NO
 - Have you had previous cosmetic surgery? YES NO
- If yes, please list _____

Name and address of local family doctor _____

Please list any other medical condition(s) you may have _____

Please list any medications you are taking (include birth control pills and vitamins)

1. _____ (how long? _____) 2. _____ (how long? _____)
3. _____ (how long? _____) 4. _____ (how long? _____)
5. _____ (how long? _____) 6. _____ (how long? _____)

Allergies to medicines? YES _____ NO _____ If yes, please list _____

Previous admissions to hospital Year Procedure

Please list the problems you will be discussing with the physician today? (LIST IN ORDER OF MOST TROUBLESOME PROBLEM)

1. _____
2. _____
3. _____

Do you have any bleeding or non-healing lesions? _____

Do you smoke? _____ If yes, how many packs per day? _____

Do you drink alcohol? _____ If yes, how many drinks per week? _____

Is there anything else you would like to tell us about your past or present medical history? _____