

**St. Louis Dermatology & Surgery Center**  
**MEDICAL HISTORY**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Reason for Visit \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Occupation \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Doctor \_\_\_\_\_

Are you pregnant?  Y  N Trying to become pregnant?  Y  N Nursing?  Y  N

Medications: name, dose & frequency	Allergies

Do you require antibiotics prior to dental work?  Y  N

Check all conditions you have or have had in the past:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Abnormal Bleeding      | <input type="checkbox"/> Dialysis        | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Pacemaker/Defibrillator |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Hepatitis A/B/C       | <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> Artificial joints/pins | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Thyroid Disease         |
| <input type="checkbox"/> Blood clots/DVTs       | <input type="checkbox"/> Hay Fever       | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Varicose veins          |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Heart Attack    | <input type="checkbox"/> Liver Disease         |  |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Mitral Valve Prolapse |  |

Any other medical conditions not listed above: \_\_\_\_\_

Have you ever had dental anesthesia (Novocaine/Lidocaine/Epinephrine)?  Y  N If yes, did you have an adverse reaction?  Y  N If yes, please explain \_\_\_\_\_

When exposed to sun do you:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Always burn, never tan | <input type="checkbox"/> Always burn, sometimes tan | <input type="checkbox"/> Sometimes burn, always tan | <input type="checkbox"/> Never burn, always tan |
|---|---|---|---|

Check all skin conditions you have or have had in the past:

- |  |                                 |  |                                       |
|--|---------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Atypical/Dysplastic Moles | <input type="checkbox"/> Acne   | <input type="checkbox"/> Psoriasis   | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Actinic Keratoses         | <input type="checkbox"/> Eczema | <input type="checkbox"/> Skin Cancer (basal cell, squamous cell, melanoma) | _____                                 |

If you or a family member has had skin cancer in the past, please list what kind, what relative and the treatment below:

\_\_\_\_\_

Primary Pharmacy Name: \_\_\_\_\_ Location: \_\_\_\_\_

Completed by:  Patient  Medical Assistant

Patient/Legal Guardian Signature: \_\_\_\_\_