LAKE OSWEGO DERMATOLOGY GROUP
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Date: __________ Name: ______________________________ Date of Birth: ________

Occupation: ______________________________

Current Medications: ______________________________

Allergies to Medications: ______________________________

For Women: Are you pregnant, plan to become pregnant, nursing, taking birth control pills or hormones? ____

Do you take antibiotics before dental procedures? Yes No

Do you smoke? Yes No If yes, how many packs per day? ______________________________

Do you drink alcohol? Yes No If yes, how many drinks per day? ______________________________

Do you have any of the following:

High Blood Pressure?	Yes	No	Artificial Joints?	Yes	No
Stroke?	Yes	No	Arthritis?	Yes	No
Heart Attack / Heart Failure?	Yes	No	Hepatitis?	Yes	No
Irregular Heart Beat?	Yes	No	HIV?	Yes	No
Cardiac Pacemaker?	Yes	No	Easy / Prolonged Bleeding?	Yes	No
Heart Valve Problem?	Yes	No	Blood Transfusions / Products?	Yes	No
Artificial Heart Valve?	Yes	No	Recent Surgery?	Yes	No
Trouble Breathing / Lung Problems?	Yes	No	Internal Cancer? Type: ________________	Yes	No
Seizures / Epilepsy?	Yes	No	Nerve Problems?	Yes	No
Eye Problems?	Yes	No	Organ Transplant?	Yes	No
Ear / Nose / Throat Problems?	Yes	No	Difficult Healing?	Yes	No
Gastrointestinal Problems?	Yes	No	Scars / Keloids?	Yes	No
Genital / Urinary Problems?	Yes	No	Depression/ Anxiety / Psychiatric Problems?	Yes	No
Circulation Problems?	Yes	No	Other Health Problems? ________________	Yes	No

Do you have a history of the following:

Diabetes / Thyroid Problems?	Yes	No
Lupus / Autoimmune Problems?	Yes	No
Eczema / Psoriasis?	Yes	No
Melanoma / Other Skin Cancer? ______________________________	Yes	No
Any blood relative with a history of Melanoma or other skin cancer? ________________	Yes	No