INFINITY
skin care

2019 Patient Medical History Form

Name: _____ Date: _____
Occupation: _____ Birthdate: _____
Reason for today's visit: _____
Are you allergic to any medications? ❑ Yes ❑ No
If yes, please list: _____
Have you ever had a reaction to dental or local anesthesia (novocaine)?
❑ Yes ❑ No If yes, describe the reaction: _____
Do you take antibiotics before you go to the dentist?
❑ Yes ❑ No If yes, why: _____
Do you have a pacemaker or implanted defibrillator? ❑ Yes ❑ No
If female are you pregnant or nursing? ❑ Yes ❑ No
Do you smoke? ❑ Yes ❑ No Do you drink alcohol? ❑ Yes ❑ No How much? _____
List all medications and topicals that you use regularly, including prescriptions, over the counter meds,
Vitamins and herbal supplements: _____
_____

Do you now have, or have you ever had the following diseases or conditions? (Yes or no)

Skin Cancer	❑ Yes ❑ No	If yes, list: _____
Family history of skin cancer	❑ Yes ❑ No	If yes, list: _____
Specific skin conditions	❑ Yes ❑ No	If yes, list: _____
Cold sores	❑ Yes ❑ No	If yes, list: _____

Do you have any of these health conditions:

High Blood Pressure	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No
History of Heart Attack	❑ Yes ❑ No	Asthma	❑ Yes ❑ No
Coronary Artery Disease	❑ Yes ❑ No	Chronic Cough	❑ Yes ❑ No
Undiagnosed Chest Pain	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No
Shortness of Breath	❑ Yes ❑ No	Wheezing	❑ Yes ❑ No
Irregular Heartbeat	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Artificial Heart Valve	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No
Peripheral Vascular Disease	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No
Congestive Heart Failure	❑ Yes ❑ No	Seasonal Allergies	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Bleeding/Clotting Disorder	❑ Yes ❑ No
Kidney Disease	❑ Yes ❑ No	Varicose Veins	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Gastrointestinal Disease	❑ Yes ❑ No
Epilepsy/Seizure	❑ Yes ❑ No	Liver Disease/Hepatitis	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	Artificial Joints	❑ Yes ❑ No
Mental Illness	❑ Yes ❑ No	HIV	❑ Yes ❑ No

List any other conditions/major surgeries:
_____
Completed by: ❑ Patient ❑ Family Member (Read and Reviewed with the Patient)
Patient Signature: _____ Date: _____
Provider Signature: _____ Date: _____

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