LAKE OSWEGO DERMATOLOGY GROUP

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PATIENT PAST MEDICAL HISTORY FORM

Date: _____ Name: _____Date of Birth: _____
Occupation: _____
Current Medications: _____
Allergies to Medications: _____

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? _____

(Women Only) Are you pregnant, plan to become pregnant, nursing, taking birth control pills or hormones? _____

Do you have any of the following:

High Blood Pressure	Y	N	Artificial Joints	Y	N
Stroke	Y	N	Arthritis	Y	N
Heart Attack / Heart Failure	Y	N	Hepatitis	Y	N
Irregular Heart Beat	Y	N	HIV	Y	N
Cardiac Pacemaker	Y	N	Easy / Prolonged Bleeding	Y	N
Heart Valve Problem	Y	N	Blood Transfusions / Products	Y	N
Artificial Heart Valve	Y	N	Recent Surgery	Y	N
Trouble Breathing / Lung Problems	Y	N	Internal Cancer	Y	N
Seizures / epilepsy	Y	N	Nerve Problems	Y	N
Eye Problems	Y	N	Organ Transplant	Y	N
Ear / Nose / Throat Problems	Y	N	Scar / Keloids	Y	N
Gastrointestional Problems	Y	N	Problems healing	Y	N
Genital / Urinary Problems	Y	N	Depression/ Anxiety / Psychiatric Problems	Y	N
Circulation	Y	N	Other Health Problems	Y	N

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 / Skin cancer	Yes	No