

Patient Medical History

Steven M. Kern, MD

Patient Name _____ Date _____

PLEASE INDICATE BY (x)

YES NO

1. Are you in good health generally? YES NO

2. Are you under the care of a physician? YES NO

If YES, for what purpose?

3. (Women) Are you pregnant/nursing? YES NO

4. Are you sensitive or allergic to:

Penicillin? YES NO

Lidocaine Anesthetic? YES NO

Any other drugs? YES NO

If YES, please list:

5. Are you subject to extensive bleeding when cut? YES NO

6. Do you take aspirin, or aspirin containing products? YES NO

7. Are you subject to overgrown scars or keloids? YES NO

8. Have you had an unusual amount of sun exposure? YES NO

9. Do you have any history of High Blood Pressure, Heart Trouble, Emotional Disorder, Diabetes, Asthma, Tuberculosis/Lung Disease, Blood Disease, Kidney or Liver Disease, Rheumatic Fever, Peptic Ulcer, Hepatitis, or Glaucoma?

If so, underline which.

12. Do you have a history of skin disease? YES NO

If YES, please explain:

YES NO

11. Have you, or anyone in your family, had Skin Cancer? YES NO

12. Are you taking prescription or non-prescription medications? YES NO

Please explain which ones:

13. Do you drink? YES NO
Number of cocktails/beers/glasses per week? _____

14. Do you smoke? YES NO
Number of packs per day _____

15. Have you ever had surgery? YES NO
Please list with approximate dates:

16. When was your last physical examination?

17. Are you now, or in the last 5 years, under the care of a psychiatrist? YES NO

18. Height _____

Weight _____

Number of pregnancies? _____

Number of births? _____

Signature _____