

NEW PATIENT HISTORY

Patient: _____ Date: _____

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 anesthesia (Novocaine) or local anesthesia (Lidocaine)? YES NO

Explain, if yes _____

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals)

Primary Physician _____

General Health: _____ Poor _____ Fair _____ Good _____ Excellent

Do you have now, or have you ever had, diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO	Other Systemic:	YES	NO	Infectious Disease:	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: A B or C		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	(please circle)		
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis/other STD's	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Simplex	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Connective Tissue	<input type="checkbox"/>	<input type="checkbox"/>	HPV	<input type="checkbox"/>	<input type="checkbox"/>
			Stomach Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Flat Warts	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:	YES	NO	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Molluscum	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, Vomiting,					
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	diarrhea when taking			Females:	YES	NO
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when			Could you be		
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Athritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>	Date of last		
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cycle: _____		
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Type of birth control		
Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	Previous pregnancies		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Skin:	YES	NO	Glasses/Contacts	<input type="checkbox"/>	<input type="checkbox"/>	_____		
History of Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____		
if yes, type _____			Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Family history of			Type _____			Past Medical History:		
skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Ovarian			_____		
if yes, type _____			Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____		
History of specific			Hirsutism/Hypertrichosis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
skin diseases	<input type="checkbox"/>	<input type="checkbox"/>	Cushing's disease	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Problems with healing	<input type="checkbox"/>	<input type="checkbox"/>				_____		
Excessive scarring/Keloids	<input type="checkbox"/>	<input type="checkbox"/>	Social History:	YES	NO	Past Surgical History:		
Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Skin Rashes	<input type="checkbox"/>	<input type="checkbox"/>	If yes, for how			_____		
Reaction to Medications	<input type="checkbox"/>	<input type="checkbox"/>	many years _____			_____		
Reaction to Food	<input type="checkbox"/>	<input type="checkbox"/>	_____ packs per day			_____		
Reaction to Environment	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Sensitivity to Sunlight	<input type="checkbox"/>	<input type="checkbox"/>	If yes, _____ per day			_____		

I hereby declare that I have honestly and completely answered the above questions to the best of my knowledge. I understand that it is my obligation and responsibility to notify Dr. Richard N. Sherman of any changes in my medical condition or medications during the course of my medical treatments or at follow-up visits.

Patient Signature

Date Signed

Reviewed By

Date