

**HEALTH HISTORY**

**PLEASE COMPLETE THE FOLLOWING:**

**LIST ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICINES YOU ARE NOW TAKING:**

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**HAVE YOU EVER BEEN ALLERGIC TO OR HAD ANY UNUSUAL REACTION TO A LOCAL ANESTHETIC SUCH AS NOVOCAIN, XYLOCAINE OR ADRENALIN? YES\_\_\_ NO\_\_\_**

**HAVE YOU EVER BEEN UNUSUALLY SENSITIVE TO COLD TEMPERATURES? YES\_\_\_ NO\_\_\_**

**DO YOU HAVE A HEART PACEMAKER? YES\_\_\_ NO\_\_\_ DO YOU SMOKE YES\_\_\_ NO\_\_\_**

**ARE YOU PREGNANT? YES\_\_\_ NO\_\_\_ DO YOU DRINK ALCOHOL? YES\_\_\_ NO\_\_\_**

**ARE YOU ALLERGIC TO LATEX OR RUBBER? YES\_\_\_ NO\_\_\_**

**CIRCLE IF YOU HAVE EVER HAD ONE OF THE FOLLOWING:**

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| <b>HEPATITIS OR LIVER DISEASE</b>         | <b>TUBERCULOSIS</b>                    |
| <b>BLEEDING DISORDER OR BLOOD DISEASE</b> | <b>STOMACH OR INTESTINAL DISEASE</b>   |
| <b>BLOOD TRANSFUSION</b>                  | <b>THYROID OR HORMONE DISEASE</b>      |
| <b>HEART DISEASE</b>                      | <b>ARTHRITIS OR MUSCLE DISEASE</b>     |
| <b>BLOOD VESSEL DISEASE</b>               | <b>HIGH BLOOD PRESSURE</b>             |
| <b>DIABETES</b>                           | <b>CANCER</b>                          |
| <b>KIDNEY DISEASE</b>                     | <b>SEXUALLY TRANSMITTED DISEASE</b>    |
| <b>LARGE SCARS OF KELOIDS</b>             | <b>POSITIVE HIV TEST OR AIDS</b>       |
| <b>FEVER BLISTERS ANYWHERE ON BODY</b>    | <b>ARTIFICIAL JOINT OR HEART VALVE</b> |
| <b>EPILEPSY OR NERVE DISEASE</b>          | <b>LUNG DISEASE</b>                    |

**MAJOR SURGERY (PLEASE LIST) \_\_\_\_\_**

**IF YOU HAVE ANY ALLERGIES (PLEASE LIST): \_\_\_\_\_**

**HAS ANYONE IN YOUR FAMILY HAD THE SAME PROBLEM FOR WHICH YOU ARE BEING SEEN?**

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**PRINT NAME \_\_\_\_\_ DATE \_\_\_\_\_**

**SIGNIATURE OF PATIENT/LEGAL GUARDIAN \_\_\_\_\_**

**GREENVILLE DERMATOLOGY, LLC**