elinda Girmonde, P. A.-C

Hematologic:	☐Normal	☐Anemia	☐Bleeding Problems	☐Other _____
Infections:	☐Normal	☐HIV	☐Hepatitis	☐Tuberculosis/+PPD Skin Test
	☐Other _____			
Musculoskeletal:	☐Normal	☐Arthritis	☐Artificial Joint	☐Other _____
Neurological:	☐Normal	☐Stroke	☐Seizures/Epilepsy	☐Multiple Sclerosis
	☐Other _____			
Respiratory:	☐Normal	☐Asthma	☐Emphysema	☐Other _____
Psychiatric:	☐Normal	☐Depression	☐Anxiety Attacks	☐Other _____
Others:	☐Kidney Problems		☐Cold Sores	☐Varicose Veins
	☐Require Antibiotics Prior to Dentistry			

Any other medical problems: _____

FAMILY HISTORY: ☐Eczema ☐Psoriasis ☐Other _____

COSMETIC HISTORY: ☐BOTOX Injectable Fillers ☐Laser Treatments

SOCIAL HISTORY:

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow/Widower

Occupation:

_____ **Smoking:**

☐No ☐Former ☐Yes, packs/day _____ **Alcohol:**

☐No ☐Yes, how much/often _____

By signing, I am acknowledging that I have disclosed all of my health information known to me at this time, and all of my other personal information is accurate. I understand that it is my obligation and responsibility to notify FirstCare Dermatology of Worcester of any changes in my medical information during the course of my medical treatment.

❖**SIGNATURE**_____ **Date** _____