Kevin Noreika, DMD

Medical History For Opus Treatment

Name:

Address:

Phone Number:

Age & Date of Birth:

Reason for visit (area to be treated):

Have you ever had the following?

- ☐ Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or pre-cancerous lesions such as multiple dysplastic nevi.
- ☐ Any active infection (if yes, which one) _____
- ☐ Diseases: Herpes Simplex, Systemic Lupus Erythematosus, or Porphyria.
- ☐ Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive
- ☐ medications.
- ☐ History of bleeding coagulopathies, or use of anticoagulants.
- ☐ History of keloid scarring.
- ☐ Very dry skin.
- ☐ Any skin conditions (if yes, which one) _____
- ☐ Exposure to sun or artificial tanning during the 3–4 weeks prior to treatment.
- ☐ Any recent burns on the area to be treated?

Are you pregnant? Yes No

What medications are you taking (including aspirin)?

Daily consumption of alcohol:

Allergies:

Are you taking any herbal preparations? (St. John's Wort, etc.)

If yes, list:

Do you wear contact lenses? Yes No

Skin type (when exposed to the sun without protection for about 1 hour)

- ☐ Always burns, never tans
- ☐ Always burns, sometimes tans
- ☐ Sometimes burns, sometimes tans
- ☐ Always tans
- ☐ Caucasian
- ☐ Asian
- ☐ Hispanic
- ☐ Mediterranean
- ☐ Middle Eastern
- ☐ Black

When were you last exposed to the sun (including tanning booth)?

Do you use chemical sun tanning lotions? Are you planning a holiday in the sun?

Have you been treated with any laser or any type of chemical treatment?

Are you currently using any prescription topicals on areas to be treated (ex; Retinol) ?

Patient Signature: Date: