Timothy F. Kelly M.D., P.A.

Patient Name _____ Today's Date _____ Date of Birth ___/___/_____

Primary Care Physician _____ Preferred Pharmacy_____

Name of person we may speak with regarding your care, if needed _____

Relationship _____Telephone _____ Smoking History: *Never Current Former Smoker*

Current Medications, with doses (Including non-prescription)

Allergies to Medications

Do you have or have you had any of the following

Mitral Valve Prolapse	**Y N**	**Rheumatic Fever**	**Y N**
Do you need antibiotics prior To having dental work?	**Y N**	**Epilepsy, Seizures, Fainting Spells**	**Y N**
Heart Murmur	**Y N**	**High Blood Pressure**	**Y N**
Pace Maker	**Y N**	**Heart Attack**	**Y N**
Heart Disease	**Y N**	**Skin Allergies**	**Y N**
Asthma	**Y N**	**Abnormal Bleeding**	**Y N**
Hay Fever	**Y N**	**Hemophilia**	**Y N**
Arthritis	**Y N**	**HIV/Aids**	**Y N**
Kidney Disease	**Y N**	**Liver Disease**	**Y N**
Thyroid Disease	**Y N**	**Diabetes**	**Y N**
Drug/Alcohol Dependency	**Y N**	**Glaucoma**	**Y N**
Cancer If yes, what type	**Y N**	**Specific Skin Diseases If so, what type**	**Y N**
Personal History of Skin Cancer If yes, what type?	**Y N**	**Family History of Skin Cancer If yes, what type? Which Relative?**	**Y N**
Do you smoke? Number of packs per day	**Y N**	**Do you drink alcohol? Number of drinks per week**	**Y N**