

MEDICAL HISTORY

PATIENT _____ DATE _____

Reason for today's visit: _____

Are you allergic to any medications? ___ YES ___ NO If yes, which?

1. _____ 2. _____ 3. _____ 4. _____

List all medications you are currently taking (include Rx, herbal or over the counter, aspirin etc):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

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

Bronchitis	___	___	Diabetes	___	___
Emphysema	___	___	Thyroid	___	___
Asthma	___	___	Kidney	___	___
Chronic Cough	___	___	Bladder	___	___
Morning Cough	___	___	Stomach	___	___
Vascular:			Bowel	___	___
High Blood Pressure	___	___	Hepatitis or yellow skin	___	___
Chest Pain	___	___	Glaucoma	___	___
Heart Attack	___	___	Arthritis/Joint	___	___
Irregular Heartbeat	___	___	Fainting	___	___
Pacemaker	___	___	Convulsions, Epilepsy or Seizures	___	___
Phlebitis	___	___			

Do you drink alcohol? _____ If yes _____ drinks per day?

Do you use IV drugs? _____ If yes, what? _____ How much? _____

Have you had or have you been exposed to HIV (Aids)? _____

Have you ever had dental anesthesia? _____ Any bad reaction? _____

Skin:

When you are exposed to the sun do you: ___ tan only ___ tan and burn ___ burn

Have you ever had skin cancer? _____ If so, what type? _____

Has anyone in your family had skin cancer? _____ If so, who? _____

Do you have a history of any specific skin diseases? _____

If yes, please list: _____

List any other disease or condition we should know about: _____

List surgical procedures you have had in the last 6 months: _____

Please answer the following questions:

Do you smoke? _____ If yes, how many per day? _____

Do you bleed easily? _____

(Women) Are you pregnant? _____

Do you have artificial joint(s)? _____

What is your occupation? _____ Hobbies: _____

Patient Signature: _____