MEDICAL HISTORY

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? ☐ YES ☐ NO If yes, list:
1. _____ 2. _____

List all Medications you are currently taking:
1. _____ 3. _____
2. _____ 4. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs	YES	NO
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐

Vascular:		
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heart Beat	☐	☐
Pacemaker	☐	☐
Phlebitis	☐	☐

Other Systemic:	YES	NO
Diabetes	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Bladder	☐	☐
Stomach	☐	☐
Bowel	☐	☐
Hepatitis or Yellow Skin	☐	☐
Glaucoma	☐	☐
Arthritis/Joint Deformity	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

Do you drink alcohol? ☐ YES ☐ NO If YES _____ drinks per day
Do you use IV drugs" ☐ YES ☐ NO If YES, what? _____ How much? _____
Have you had or have you been exposed to HIV (AIDS)? ☐ YES ☐ NO
Have you ever had dental anesthesia (Novocaine)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

Skin:

When you are exposed to sun do you: ☐ Tan only ☐ Tan and burn ☐ Burn
Have you ever had skin cancer? ☐ YES ☐ NO
Has anyone in your family had skin cancer? ☐ YES ☐ NO If YES, Who? _____
Do you have a history of any specific skin diseases? ☐ YES ☐ NO
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:

A.	Do you smoke?	☐ YES	☐ NO	If YES, how much: _____
B.	Do you bleed easily?	☐ YES	☐ NO	
C.	(Women) Are you pregnant?	☐ YES	☐ NO	Due Date _____
D.	Do you have artificial joint(s)?	☐ YES	☐ NO	

E. What is your occupation? _____
F. What are your hobbies? _____

Completed by: ☐ Patient
☐ Medical Assistant _____ Initials

_____
Signed by Physician Date

_____
Reviewed by Date