Medical History

Patient: ______________________ Age: __________ Date: __________

Reason for today's visit: ______________________________

Are you allergic to any medications? ☐ Yes ☐ No if yes, list:

1. ______________________ 3. ______________________

2. ______________________ 4. ______________________

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)

	Yes	No
Emphysema	☐	☐
Asthma	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Pacemaker	☐	☐
Defibulator	☐	☐

	Yes	No
Diabetes	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
Arthritis	☐	☐
Artificial Joint	☐	☐
Organ Transplant	☐	☐
Yeast Infection when taking anti-biotics	☐	☐
Nausea, Diarrhea when taking anti-biotics	☐	☐

List any other disease or conditions: ______________________________

List any surgical procedures in the past 6 months: ______________________________

	Yes	No
Have you ever had skin cancer or melanoma?	☐	☐
Has anyone in your family had skin cancer or melanoma?	☐	☐
Do you have problems with healing?	☐	☐
Do you develop keloids (scars) after surgery?	☐	☐
Do you bleed easily?	☐	☐
Do you develop skin rashes in reaction to: ☐ Bandages ☐ Topical Neosporin		
Have you had or have you been exposed to HIV (AIDS)?	☐	☐
Have you been diagnosed with hepatitis B or C?	☐	☐

Do you give our office permission to discuss your medical information with family members?
☐ Yes ☐ No if yes, please provide their names and phone numbers below:

Name: ______________________ Relationship: ______________________

Phone # (day): (____)__________________ Phone # (evening): ______________________

Name: ______________________ Relationship: ______________________

Phone # (day): (____)__________________ Phone # (evening): ______________________

Emergency Contact Information:
In case of Emergency, whom should we notify? ______________________________

Relationship to Patient: ______________________ Phone: (____)__________________

May we leave personal medical information on your answering machine at home? ☐ Yes ☐ No

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Signed by Patient Date