Medical History

Name: ______________________________ Today's Date: ____________________

First Middle Last

Reason for Today's Visit: ______________________________

Primary Care / Referring Physician: ______________________________

Are you allergic to any medications: ❑ No ❑ Yes, they are listed below:

1. ____________ 2.____________ 3.____________

List all the medications you are currently taking (including prescriptions, over-the-counter meds, vitamins and/or herbals):

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
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑
Wheezing	❑	❑

CARDIOVASCULAR	YES	NO
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of vein	❑	❑
Blood clots	❑	❑
Pacemaker	❑	❑

OTHER SYSTEMIC	YES	NO
Diabetes	❑	❑
Excessive thirst/hunger	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Bladder Frequency/burning	❑	❑
Gastrointestinal		
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthralgia	❑	❑
Limited motion	❑	❑
Artificial joint	❑	❑
Epilepsy/Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions: ______________________________

List surgical procedures you have had in the past 2 years: ______________________________

SKIN

Have you ever had skin cancer? ❑ YES ❑ NO

Has anyone in your family had skin cancer? ❑ YES ❑ NO

Do you have a history of any specific skin diseases? ❑ YES ❑ NO If yes, ____________

Do you have any problems with healing? ❑ YES ❑ NO

Do you develop keloids (scars) after surgery? ❑ YES ❑ NO

Do you bleed easily? ❑ YES ❑ NO

Do you develop skin rashes in reaction to: ❑ Medications ❑ Food ❑ Environment

SOCIAL HISTORY

Do you drink alcohol? ❑ YES ❑ NO if YES, ________ drinks per day

Do you use IV drugs? ❑ YES ❑ NO if YES, what? ____________ How often?________

Do you smoke? ❑ YES ❑ NO if YES, how much: ____________

Women, please answer the following questions:

Are you pregnant? ❑ YES ❑ NO If YES: Due Date: : ___/___/___ Are you breastfeeding? ❑ YES ❑ NO

Have you had: Hysterectomy ❑ YES ❑ NO / Bilateral Tubal Ligation ❑ YES ❑ NO

What is your occupation? ____________________ Hobbies? ____________________

Completed by: ❑ Patient/Guardian

❑ Medical Assistant ______

____________________ ___/___/___

Signed by Patient

____________________ ___/___/___

Reviewed by