Medical History

Patient:_____ Date:_____

Reason for today's visit: _____

Are you allergic to any medications? _____ YES _____NO If yes, list:

_____

List all medication you are currently taking including vitamins: _____

_____

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

Lungs:	YES	NO
Emphysema	_____	_____
Asthma	_____	_____
Vascular:		
High Blood Pressure	_____	_____
Heart Attack	_____	_____
Heart Murmur	_____	_____
Irregular Heart Beat	_____	_____
Pacemaker	_____	_____

Other Systemic:	YES	NO
Diabetes	_____	_____
Hyperthyroidism	_____	_____
Hypothryroidism	_____	_____
Bowel	_____	_____
Hepatitis/Yellow Skin	_____	_____
Glaucoma	_____	_____
Arthritis/Joint Deformity	_____	_____
Convulsions, Epilepsy, Or Seizures	_____	_____
Fainting	_____	_____

Do you drink alcohol? _____ If yes, how many 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 (Novocaine)?_____ Any bad Reactions? ____

_____

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

_____

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

_____

Please Turn Over

Skin:

Have you ever had skin cancer? _____YES _____NO

If yes, what type? _____

Has anyone in your family had skin cancer? _____YES _____NO

If yes, what type? _____

Do you have a history of specific skin diseases? _____YES _____NO

If yes, please list: _____

Do you have any problems with wound healing? _____YES _____NO

Do you scar easily? _____YES _____NO

Please answer the following questions:

Do you smoke? _____YES _____NO

If yes, how much: _____

Are you a former smoker? _____YES _____NO

Do you bleed easy? _____YES _____NO

(Women) Are you pregnant? _____YES _____NO

If yes, due date? _____

Do you have artificial joint(s)? _____YES _____NO

What is your occupation? _____

What are your hobbies? _____

Completed by: _____Patient

_____Parent/Guardian

_____Medical Assistant _____

Initials

_____

Patient/Guardian Signature Date