MEDICAL HISTORY

PATIENT: _____ **FAMILY PHYSICIAN:** _____ **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 taking: including prescription / non-prescription drugs, vitamins, herbs, dietary or any other supplements.

1. _____ **4.** _____

2. _____ **5.** _____

3. _____ **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	☐	☐
			Stomach	☐	☐
Vascular:			Bowel	☐	☐
			Glaucoma	☐	☐
High Blood Pressure	☐	☐	Arthritis/Joint Deformity	☐	☐
Chest Pain	☐	☐	Convulsions, Epilepsy, or		
Heart Attack	☐	☐	Seizures	☐	☐
Heart Murmur	☐	☐	Fainting	☐	☐
Irregular Heart Beat	☐	☐	Hepatitis (of any type)	☐	☐
Pacemaker	☐	☐	Herpes	☐	☐
				_____Lip (cold sores)	_____Genital
Phlebitis	☐	☐	Syphilis	☐	☐
			Genital Warts	☐	☐

Do you drink alcohol? ☐YES ☐NO **IF YES** _____ **drinks per day Beer**_____ **Wine**_____ **Hard Liquor**_____

Do you use recreational, illicit, or 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 (Novocain)? ☐ YES ☐ NO **Any bad reaction?** ☐ YES ☐ NO

Have you ever had local anesthesia (Xylocaine, Marcaine)? ☐ YES ☐ NO **Any bad reaction?** ☐ YES ☐ NO

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, hair, or nail diseases? ☐ YES ☐ NO **If yes, Please list** _____

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

List all cosmetic procedures you have had: _____

List all rub on creams, lotions, or medicine you are using: _____

List surgical procedures you have had: _____

Do you scar easily or excessively? ☐ YES ☐NO **Describe** _____

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 **Last menstrual period** _____ ☐ **Reg.** ☐ **Irreg.**

D. Do you have any 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**