MEDICAL HISTORY

Patient:_____DOB:_____Today's Date_____
Last *First* *M.I.*

Reason for today's visit:_____

Are you allergic to any medications? ☐Yes ☐ No If yes,explain:_____
Are you allergic to topical antibiotics or bandaids? ☐Yes ☐ No
List all medications you are currently taking:_____

_____

Significant past or current health problems:_____

_____

Are you taking: Aspirin/Blood Thinner? ☐Yes ☐ No Coumadin? ☐Yes ☐ No
Non-Steroidal anti-inflammatory drugs? ☐Yes ☐ No
Do you use tobacco products? ☐Yes ☐ No
History of Depression, Mental Illness, Anxiety? ☐Yes ☐ No
Do you have now, or have you ever had diseases or conditions of: (Please circle YES or NO)

LUNGS:

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

VASCULAR

High Blood Pressure	YES	NO
Chest Pain	YES	NO
Heart Attack	YES	NO
Heart Murmur	YES	NO
Irregular Heartbeat	YES	NO
Pacemaker	YES	NO
Phlebitis	YES	NO
Artificial Heart Valve	YES	NO
Bleeding Disorder	YES	NO

Other Systemic

Diabetes	YES	NO
Thyroid	YES	NO
Kidney	YES	NO
Bladder	YES	NO
Bowel	YES	NO
Hepatitis	YES	NO
Glaucoma	YES	NO
Arthritis/joint deformity	YES	NO
Convulsions/epilepsy/seizures	YES	NO
Fainting	YES	NO
Headaches	YES	NO
Joint Replacement	YES	NO
Organ Transplant	YES	NO

Who is your primary care doctor/internist?_____

Preferred Pharmacy:_____

SKIN

When you are exposed to the 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 disease? ☐ YES ☐ NO If yes, please list:_____

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This section for Women only:

Are you on birth control pills? ☐ YES ☐ NO Do you have endometriosis? ☐ YES ☐ NO
Other contraceptive?_____
Are you pregnant? ☐ YES ☐ NO
If yes, due date?_____

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Reviewed by: Date:

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