

MEDICAL HISTORY

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? [] Yes [] No
If yes please list:

Do you have now or have you ever had the following diseases or conditions:

Lungs:	Yes / No	Other Systemic:	Yes / No	Vascular:	Yes / No
Bronchitis	[] []	Diabetes	[] []	High Blood Pressure	[] []
Emphysema	[] []	Thyroid	[] []	Glaucoma	[] []
Asthma	[] []	Kidney	[] []	Chest Pain	[] []
Chronic Cough	[] []	Bladder	[] []	Heart Attack	[] []
Morning Cough	[] []	Stomach	[] []	Heart Mummer	[] []
	[] []	Bowel	[] []	Irregular	[] []
	[] []	Hepatitis	[] []	Pacemaker	[] []
	[] []	Arthritis	[] []	Phlebitis	[] []
	[] []	Joint Deformity	[] []		[] []
	[] []	Convulsions, Epilepsy, Seizures	[] []		[] []
	[] []	Fainting	[] []		[] []
	[] []	Heart Beat	[] []		[] []

Do you drink alcohol? [] Yes [] No

If yes, _____ drinks per day

Do you use IV drugs? [] Yes [] No

If yes, what? _____ How much? _____

Have you ever 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

Skin:

When exposed to the sun do you [] Tan [] Tan and Burn [] Burn

Have you ever had skin cancer? [] Yes [] No

Has anyone in your family ever had skin cancer? [] Yes [] No

Do you have any history of any skin diseases? [] Yes [] No

If yes, please list: _____

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

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

Please answer the following questions:

Do you smoke? [] Yes [] No If yes, how much:_____

Do you bleed easily? [] Yes [] No

Are you pregnant? [] Yes [] No Due date:___/___/___

Do you have artificial joint(s)? [] Yes [] No

What is your occupation?_____

What are your hobbies?_____

Completed by:

[] Patient:_____

[] Medical Assistant, Initials_____

Signed by Physician:_____ Date___/___/___