MEDICAL HISTORY

Patient:_____ 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:_____

_____

Previous surgeries _____

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

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:_____

This section for Women only:

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

Do you have endometriosis? ☐ YES ☐ NO

Reviewed by: Date:

_____

_____

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SAVE PDF