MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** _____
Today's Date: _____

Reason for today's visit: _____
Are you allergic to any medications? Yes ☐ No ☐ **If yes, please list below:** _____

List all medications you are currently taking: _____

Do you have now, or have you ever had diseases or conditions of the following?

LUNGS:	Yes	No
Asthma	☐	☐
Bronchitis	☐	☐
Chronic Cough	☐	☐
Emphysema	☐	☐
VASCULAR:		
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Pacemaker	☐	☐
Phlebitis	☐	☐
Bleed Easily	☐	☐

Other Systemic:	Yes	No
Diabetes	☐	☐
Thyroid	☐	☐
Bladder	☐	☐
Bowel Problems	☐	☐
Hepatitis	☐	☐
Glaucoma	☐	☐
Arthritis/Joint Pain	☐	☐
Convulsions	☐	☐
Epilepsy	☐	☐
Seizures	☐	☐
Fainting	☐	☐
Are you pregnant?	☐	☐

Due Date: _____

HABITS:

Do you smoke?	☐	☐
How much?	_____	packs
Do you use IV drugs:	☐	☐
Have you had or have been exposed to HIV (AIDS)	☐	☐

Do you drink alcohol:	☐	☐
How many drinks per day?	_____	
If yes, what and how much?	_____	
Have you ever had dental anesthesia (Novacaine)?	☐	☐
Bad Reaction?	☐	☐

SKIN:

When exposed to the sun do you Tan only ☐ Tan & Burn ☐ Burn ☐

Have you ever had skin cancer? ☐ Yes ☐ No If yes, what kind: _____

Has anyone in your family had skin cancer: ☐ Yes ☐ No
If yes, what kind: _____

Do you have a history of specific skin diseases? ☐ Yes ☐ No If yes, list below:
_____

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

List any surgical procedures done in the last 6 months: _____

What are your hobbies _____ What is your occupation? _____

Completed by: Patient ☐ or Parent ☐ MD's Signature: _____