

Medical History

Patient: _____

Date: _____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, list:
 1. _____ 2. _____

List all Medications you are currently taking:
 1. _____ 3. _____
 2. _____ 4. _____

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	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/>
			Bowel	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis or Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>
			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

Vascular:

High Blood Pressure YES NO
 Chest Pain YES NO
 Heart Attack YES NO
 Heart Murmur YES NO
 Irregular Heart Beat YES NO
 Pacemaker YES NO
 Phlebitis YES NO

Do you drink alcohol? YES NO If YES _____ drinks per day
 Substance Abuse? 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 (Novacaine)? YES NO Any bad reaction? YES NO

Skin:

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 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:

A. Do you smoke? YES NO If yes, how much: _____
 B. Do you bleed easily? YES NO
 C. (Women) Are you pregnant? YES NO Due Date: _____
 D. Do you have artificial joint(s)? YES NO
 E. What is your occupation? _____
 F. What are your hobbies? _____

Completed by: Patient
 Other _____

Signed by Physician _____ Date _____

Reviewed by _____ Date _____