

MEDICAL HISTORY

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

Age: _____ Sex M F Are you pregnant or nursing? Yes No

What is today's problem? _____ How long has it been a problem? _____

Are you allergic to any medications, metals, food, etc.? Yes No If yes, please list: _____

Have you ever had dental anesthesia (Novocaine)? Yes No If yes, any reaction? Yes _____ No

Do you experience nausea, vomiting, diarrhea, or yeast infections when taking antibiotics? Yes No

List all medications you are currently taking (including prescriptions, over-the-counter medications, supplements, and herbals:) _____

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

	Yes	No		Yes	No
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Oxygen use	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/digestive problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Artificial valves/joints	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy, Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Depression/anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Other psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>			

List any other diseases or conditions: _____

List surgical procedures you have had: _____

Skin: Have you ever had skin cancer? Yes No
Has anyone in your family had skin cancer? Yes No
Do you have a history of any specific skin diseases? Yes No If yes, _____
Do you have any problems healing? Yes No
Do you develop keloids (scars) after surgery? Yes No
Do you bleed easily? Yes No
Do you develop skin rashes in reaction to Medications Food Environment Bandages Topical Neosporin
Adhesives Latex Other _____

Social history: Do you drink alcohol? Yes No Do you smoke? Yes No
Do you use IV drugs? Yes No
What is your occupation? _____ Hobbies? _____
Are you: Married Single Widowed Other

Family history: Is there a family history of any of the following? eczema, psoriasis, hay fever, asthma, diabetes, heart disease, cancer, tuberculosis, peptic ulcer, hypertension, hepatitis, thyroid disease, arthritis