

# MEDICAL HISTORY

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Are you allergic to any medications?  Y  N

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

List ALL medications you are currently taking & reason

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

Do you have now, or have you ever had diseases or conditions of

### LUNG

Bronchitis  Y  N

Emphysema  Y  N

Asthma  Y  N

Chronic Cough  Y  N

Morning Cough  Y  N

### OTHER SYSTEMIC

Diabetes  Y  N

Thyroid  Y  N

Kidney  Y  N

Bladder  Y  N

Stomach  Y  N

Bowel  Y  N

Hepatitis or Yellow Skin  Y  N

Glaucoma  Y  N

Arthritis/Joint Deformity  Y  N

Convulsions/Epilepsy/Seizures  Y  N

Fainting  Y  N

Answered YES to any please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### VASCULAR

High Blood Pressure  Y  N

Chest Pain  Y  N

Heart Attack  Y  N

Heart Murmur  Y  N

Irregular Heartbeat  Y  N

Pacemaker  Y  N

Phlebitis  Y  N

### SKIN

When you are exposed to sun, do you  Tan only  Tan and Burn  Burn

Have you ever had skin cancer?  Y  N What type? \_\_\_\_\_

Has anyone in your family had skin cancer?  Y  N Who and what type? \_\_\_\_\_

Do you have a history of any specific skin diseases?  Y  N 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 \_\_\_\_\_

List any hospitalizations you have in the last 6 months \_\_\_\_\_

### PLEASE ANSWER THE FOLLOWING QUESTIONS

Do you drink alcohol?  Y  N If yes \_\_\_\_\_ drinks per week.

Do you use IV drugs?  Y  N If yes, what? \_\_\_\_\_ How much? \_\_\_\_\_

Have you had or have you been exposed to HIV (AIDS)?  Y  N

Have you ever had dental anesthesia (Novocaine)?  Y  N If yes, any bad reaction?  Y  N

If yes, please describe \_\_\_\_\_

Do you smoke?  Y  N If yes, how much? \_\_\_\_\_

Do you bleed easily?  Y  N

(Women) Are you pregnant?  Y  N Due date \_\_\_\_\_

What is your occupation? \_\_\_\_\_ What are your hobbies? \_\_\_\_\_

Completed by:  Patient  Nurse \_\_\_\_\_ (initials)

Provider signature and date \_\_\_\_\_