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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

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

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_____

_____

_____

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