

## 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 \_\_\_\_\_