

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 if so)

Lungs:

- Bronchitis
- Emphysema
- Asthma
- Chronic Cough
- Morning Cough

Other Systemic:

- Diabetes
- Thyroid
- Kidney
- Bladder
- Stomach
- Bowel
- Hepatitis or Yellow Skin
- Glaucoma
- Arthritis/Joint Deformity
- Convulsions, Epilepsy
or Seizures
- Fainting

Vascular:

- High Blood Pressure
- Chest Pain
- Heart Attack
- Heart Murmur
- Irregular Heartbeat
- Pacemaker
- Phlebitis

Do you drink alcohol? YES NO If YES _____ drinks per day
Do you use IV drugs? 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 the 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 that 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
 Medical Assistant _____
Initials

Signed by Physician _____ Date

Reviewed by _____ Date



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