MEDICAL HISTORY

Patient: _____ Date: _____

Readon for today's visit: _____

Are you allergic to any medications? YES NO If yes, list:

1. _____ 3. _____
2. _____ 4. _____

List any medications you are currently taking:

1. _____ 3. _____
2. _____ 4. _____

Medical Doctor's Name _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Vascular:		
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heart Beat	☐	☐
Pacemaker	☐	☐
Phlebitis	☐	☐

Other Systemic:	**YES**	**NO**
Diabetes	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Bladder	☐	☐
Stomach	☐	☐
Bowel	☐	☐
Hepatitis or Yellow Skin	☐	☐
Glaucoma	☐	☐
Arthritis/Joint Deformity	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

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 (Novocain)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

Skin:

When you are expose to sun do you: ☐ Tan Only ☐ Tan and Burn ☐ Burn

Have you ever had skin cancer? ☐ YES ☐ NO

Has anyone in your family ever had skin cancer? ☐ YES ☐ NO

Do you have a history of any specific skin diseases? ☐ YES ☐ NO

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: _____

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? _____