

Medical History

Patient Name _____ Date: _____

Are you allergic to any medication? Yes No If yes please list:

1. _____ 2. _____ 3. _____

List all Medications you are currently taking (including over the counter or herbal remedies):

Who is your primary Physician? _____

Have you ever had dental anesthesia (Novocain)? Yes No Any bad reaction? Yes No

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

	Yes	No		Yes	No
Lungs:			Other Systemic		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
			Gastrointestinal		
Cardiovascular:	Yes	No	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea		
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when		
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Do you bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin: Have you ever had skin cancer? Yes No
Has anyone in your family had skin cancer? Yes No
Do you have a history of any specific skin diseases? Yes No if yes, _____
Do you have problems with healing? Yes No
Do you develop keloids (scars) after surgery? Yes No
Do you develop skin rashes in reaction to: Medications Food Environment Bandages Neosporin
 Other _____

Social History:

Do you drink alcohol? Yes No If YES _____ drinks per day
Do you smoke? Yes No If YES, how much: _____
Have you had or have you been exposed to HIV (AIDS)? Yes No

Please answer the following questions:

(Women) Are you pregnant? Yes No Due date: _____

What is your occupation? _____ Hobbies? _____

WE RECOMMEND A YEARLY BODY EXAM. PLEASE SCHEDULE THIS IF YOU LIKE. PLEASE SIGN BELOW THAT YOU HAVE READ THE ABOVE STATEMENT.

Completed by:

Signed by Patient

Date:

Reviewed by

Date: