

## MEDICAL HISTORY

Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Were you referred by a doctor? (If yes, please list name) \_\_\_\_\_

If you were not referred, how did you hear about us?  Yellow Pages  Ad (list) \_\_\_\_\_

Another patient \_\_\_\_\_  Other \_\_\_\_\_

What is the primary reason for your visit? \_\_\_\_\_

Are you allergic to any medications:  Yes  No If yes, please list: \_\_\_\_\_

Please list all medications that you are currently taking:


Do you now have, or have you ever had, diseases or conditions of:

	Yes	No	Other	Yes	No
<b>Lungs</b>					
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Excessive clotting	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Embolus	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<b>Heart</b>			Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Artificial valves	<input type="checkbox"/>	<input type="checkbox"/>	Liver or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmurs	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Internal Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
			Depression or other psychiatric problem	<input type="checkbox"/>	<input type="checkbox"/>

List any other disease or condition we should know about: \_\_\_\_\_

**Skin:**

Have you ever had skin cancer?  Yes  No

If yes, list type of cancer (for example, basal cell cancer, squamous cell cancer, malignant melanoma) and location, if known: \_\_\_\_\_

Has anyone in your family had skin cancer?  Yes  No

If yes, list relation and type of cancer, if known \_\_\_\_\_

Do you have a history of specific skin diseases?  Yes  No

If yes, please list: \_\_\_\_\_

**Other:**

Do you smoke?  Yes  No    Do you drink excess alcohol?  Yes  No    Do you use drugs?  Yes  No

(Women) Are you pregnant?  Yes  No    Are you trying to get pregnant?  Yes  No

What is your occupation? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

On a scale of 1 to 10 how would you rate the appearance of your skin? 1 2 3 4 5 6 7 8 9 10 Needs help Very good

\_\_\_\_\_  
Reviewed and signed by physician or extender

\_\_\_\_\_  
Date

Information above corrected and re-reviewed

Provider Initial/Date	Provider Initial/Date	Provider Initial/Date	Provider Initial/Date	Provider Initial/Date	Provider Initial/Date