

MEDICAL HISTORY

Patient _____ Date taken: _____

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. _____ 2. _____

1. _____ 2. _____

History of Diseases

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

LUNGS:	Yes	No	Other Systemic:	Yes	No
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/>
			Bowel	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis or Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>
VASCULAR			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>			
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>			
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>			

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 (Novocaine)? Yes No Any bad reaction? Yes No

SKIN:

When you are exposed to 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

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

If yes, please list: _____

List any other diseases 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 arthritic joint(s)? Yes No

E. What is your occupation? _____

F. What are your problems? _____

Completed by: Medical Assistant _____ Patient _____

Initials

Signed by _____ Date _____