# MEDICAL HISTORY

**Patient Name** **Date**

**Reason for today's visit:**

**Are you allergic to any medications/foods/other?** ☐ **Yes** ☐ **No** **If "Yes," please list:**

**List all medications you are currently taking:**

| Name | Dose | How often | Name | Dose | How often |
|---|---|---|---|---|---|
| | | | | | |

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

**LUNGS**

| | | |
|---|---|---|
| Bronchitis | ☐ **Yes** | ☐ **No** |
| Emphysema | ☐ **Yes** | ☐ **No** |
| Asthma | ☐ **Yes** | ☐ **No** |
| Chronic Cough | ☐ **Yes** | ☐ **No** |
| Morning Cough | ☐ **Yes** | ☐ **No** |

**VASCULAR**

| | | |
|---|---|---|
| High Blood Pressure | ☐ **Yes** | ☐ **No** |
| Chest Pain | ☐ **Yes** | ☐ **No** |
| Heart Attack | ☐ **Yes** | ☐ **No** |
| Heart Murmur | ☐ **Yes** | ☐ **No** |
| Irregular Heart Beat | ☐ **Yes** | ☐ **No** |
| Pacemaker | ☐ **Yes** | ☐ **No** |
| Phlebitis | ☐ **Yes** | ☐ **No** |

**SYSTEMIC**

| | | |
|---|---|---|
| Diabetes | ☐ **Yes** | ☐ **No** |
| Thyroid | ☐ **Yes** | ☐ **No** |
| Kidney | ☐ **Yes** | ☐ **No** |
| Bladder | ☐ **Yes** | ☐ **No** |
| Stomach | ☐ **Yes** | ☐ **No** |
| Bowel | ☐ **Yes** | ☐ **No** |
| Hepatitis or Yellow Skin | ☐ **Yes** | ☐ **No** |
| Glaucoma | ☐ **Yes** | ☐ **No** |
| Arthritis/Joint Deformity | ☐ **Yes** | ☐ **No** |
| Convulsions/Epilepsy/Seizures | ☐ **Yes** | ☐ **No** |
| Fainting | ☐ **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** **If "Yes," what type and when?**
**date:**

Has anyone in your family had skin cancer?
☐ **Yes** ☐ **No** **If "Yes," what type?**

Do you have a history of any specific skin diseases?
☐ **Yes** ☐ **No** **If "Yes," what type?**

**OTHER**

Do you drink alcohol ☐ **Yes** **If "Yes," how many drinks per day** ☐ **None** ☐ **One** ☐ **Two** ☐ **More**

Do you use IV drugs? ☐ **Yes** ☐ **No** **If "Yes," what?** **How often?**

Have you had or have you been exposed to HIV(AIDS)? ☐ **Yes** ☐ **No**

Have you ever had dental anesthesia (Novacaine) ☐ **Yes** ☐ **No** **Any bad reactions?**

List any other diseases or condition we should know about:

List surgical procedures:

Do you smoke? ☐ **Yes** ☐ **No** **If "Yes," how much?**

Do you bleed easily? ☐ **Yes** ☐ **No**

Are you pregnant? (women) ☐ **Yes** ☐ **No**

Do you have arthritic joint(s)? ☐ **Yes** ☐ **No**

List your occupation:

**Signed by** **Date**