

Medical History

Patient: _____ Date _____

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. _____ 3. _____
 2. _____ 4. _____

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

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"/>
			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

Vascular:

High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Irregular HeartBeat	<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 If YES, what? _____
 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? _____

Completed by: Patient
 Medical Assistant _____
Initials

 Signed Physician Date

 Reviewed by Date