

Medical History Form

Patient Name: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? Yes No If yes, list below:

1. _____ 2. _____

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

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins and herbal treatments):

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Do you have now, or have you ever had any of the following diseases or conditions?

	Yes	No	Other Systemic:	Yes	No
Lungs:					
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"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
			Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:	Yes	No	Nausea, vomiting, diarrhea when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy, or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>			
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>			

Skin:

When you are exposed to the sun do you: Tan only Tan and Burn Burn

Have you ever been diagnosed with skin cancer? Yes No If yes, what type and when?

Has anyone in your family had skin cancer? Yes No If yes, what type and whom?

Skin cont.

Do you have a history of any other skin disease? Yes No If yes, please list below:

Do you develop skin rashes in reaction to: Medications Food The Environment

Please explain: _____

List any other diseases or medical conditions: _____

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

Social History:

Do you drink alcohol? Yes No If yes, how often? daily weekly occasionally

Do you use IV drugs? Yes No If yes, what type and how often? _____

Do you smoke? Yes No If yes, how much? _____

Have you ever been exposed to, had, or currently have HIV (AIDS)? Yes No

Please answer the following questions:

A. Do you bleed easily? Yes No

B. Are you pregnant (women)? Yes No Maybe Due Date: _____

C. What is your occupation? _____

D. What are your hobbies? _____

Completed by: Patient Nurse/MA - Initials: _____

Patient Signature: _____ Date: _____

Reviewer Signature: _____ Date: _____