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MEDICAL HISTORY

Patient: _____ Date Of Birth: _____ Today's Date: _____

Primary Care Physician: _____

Are You Allergic To Any Medications? Yes No

If "Yes" Please Specify: _____

List Any Medications You Are Currently Taking: (Including Aspirin, Over The Counter Meds, Vitamins And Herbals):

Do You Have Now, Or Ever Had, The Following Diseases Or Conditions: (Please Check Yes Or No)

Table with 6 columns: Disease/Condition, Yes, No, Disease/Condition, Yes, No. Rows include Arthritis/Joint Deformity, Artificial Joint, Asthma, Bladder, Blood Clots, Cancer, Cataracts/Glaucoma, Epilepsy/Seizures, Diabetes, Emotional/Psychiatric, Fainting, Gastrointestinal Disorder, Hearing Loss, Heart Attack, Heart Disease, Heart Murmur, Hepatitis, Herpes Breakouts, High Blood Pressure, High Cholesterol, HIV Positive/HIV Exposure, Irregular Heartbeat, Kidney, Liver-Gallbladder, Mitral Valve Prolapse, Pacemaker, Polycystic Ovaries, Thyroid, Tuberculosis/Lung, Venereal Disease.

List Any Other Diseases or Conditions Not Listed Above:

List Any Surgical Procedures You Have Had In The Last Year:

Skin:

Have You Ever Had Skin Cancer?

Yes No If Yes, Please Specify: _____

Do You Have A History Of Any Specific Skin Diseases?

Yes No If Yes, Please Specify: _____

Do You Have Any Problems With Healing?

Yes No If Yes, Please Specify: _____

Do You Develop Raised Scars After Surgery?

Yes No If Yes, Please Specify: _____

Do You Bleed Easily?

Yes No If Yes, Please Specify: _____

Do You Develop Skin Rashes In Reaction To Any Medications, Food, Or The Environment?

Yes No

If Yes, Please Explain: _____

Social History:

Do You Drink Alcohol? Yes No If Yes, Please Specify: _____

Do You Use Recreational Drugs? Yes No If Yes, Please Specify: _____

Do You Smoke? Yes No If Yes, Please Specify: _____

Family History:

Who and What Type? (Ex. – Father, prostate cancer)

Arthritis Yes No _____

Diabetes Yes No _____

Eczema Yes No _____

Heart Disease Yes No _____

High Blood Pressure Yes No _____

High Cholesterol Yes No _____

Lupus Yes No _____

Psoriasis Yes No _____

Thyroid Problems Yes No _____

Skin Cancer Yes No _____

Other Cancer Yes No _____

Females only:

Menstrual Cycle: (Circle One)

Regular Irregular None

Are You Pregnant or Planning A Pregnancy

Yes No

Are You Currently Breast Feeding?

Yes No

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