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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):

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

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

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 ☐	______________________________

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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 ☐	

Rev'd By: ______________	**Date:** ________	**Rev'd By:** ______________	**Date:** ________
Rev'd By: ______________	**Date:** ________	**Rev'd By:** ______________	**Date:** ________
Rev'd By: ______________	**Date:** ________	**Rev'd By:** ______________	**Date:** ________
Rev'd By: ______________	**Date:** ________	**Rev'd By:** ______________	**Date:** ________
Rev'd By: ______________	**Date:** ________	**Rev'd By:** ______________	**Date:** ________
Rev'd By: ______________	**Date:** ________	**Rev'd By:** ______________	**Date:** ________
Rev'd By: ______________	**Date:** ________	**Rev'd By:** ______________	**Date:** ________