PATIENT MEDICAL HISTORY

Patient Name: _____ **Today's Date:** ___ ___ /___ ___/___ ___

Reason for today's visit: _____

MEDICAL HISTORY

Have you ever been diagnosed with any of the following: *(please circle)*

CARDIOVASCULAR

Arrhythmia	YES	NO
Blood Clots	YES	NO
Heart Attack	YES	NO
Heart Murmur	YES	NO
Hypertension	YES	NO

NEUROLOGICAL

Seizures	YES	NO
Stroke	YES	NO

RESPIRATORY

Asthma	YES	NO
COPD / Emphysema	YES	NO

OTHER SYSTEMIC

AIDS or HIV	YES	NO
Anemia	YES	NO
Arthritis	YES	NO
Bladder Disorder	YES	NO
Cancer (**non-skin**)	YES	NO
If yes, please specify: _____		
Chicken Pox	YES	NO
Cold Sores	YES	NO
Diabetes	YES	NO
GI Disorder	YES	NO
High Cholesterol	YES	NO
Liver Disorder or Hepatitis	YES	NO
Thyroid Disorder	YES	NO
Vasovagal (e.g. fainting)	YES	NO

MEDICATIONS

Please list ALL medications you are currently taking:

(include prescriptions, over-the-counter meds, vitamins, and supplements)

_____ _____

_____ _____

_____ _____

Please circle YES or NO for the following:

Do you take antibiotics before surgical procedures?	YES	NO
Do you have an artificial joint or an artificial heart valve?	YES	NO
Do you have a pacemaker and/or defibrillator?	YES	NO

ALLERGIES

Please list all medications or substances to which you have a known allergy or sensitivity:

_____ _____

_____ _____

Do you have an allergy or known sensitivity to: *(please circle)*

Latex	YES	NO
Lidocaine, Novocaine, or Xylocaine	YES	NO
Epinephrine	YES	NO
Adhesive tape	YES	NO
Topical Betadine or Iodine	YES	NO

Please list any other medical conditions you have:

_____

DERMATOLOGICAL HISTORY

Have you ever been diagnosed with: *(please circle)*

Eczema	YES	NO
Psoriasis	YES	NO
Basal Cell Carcinoma	YES	NO
Squamous Cell Carcinoma	YES	NO
Malignant Melanoma	YES	NO
Mycosis Fungoides	YES	NO
Cutaneous T-cell Lymphoma	YES	NO

FAMILY DERMATOLOGICAL HISTORY

Does any *blood relative* have a history of: *(please circle)*			**Relationship to you:**
Eczema	YES	NO	_____
Psoriasis	YES	NO	_____
Basal Cell Carcinoma	YES	NO	_____
Squamous Cell Carcinoma	YES	NO	_____
Malignant Melanoma	YES	NO	_____
Mycosis Fungoides	YES	NO	_____
Cutaneous T-cell Lymphoma	YES	NO	_____

SOCIAL HISTORY

Please circle YES or NO for the following:

Do you drink alcohol?	YES	NO	If yes, _____ drinks per week
Do you smoke?	YES	NO	If yes, how many cigarettes per day? _____
Do you use recreational drugs?	YES	NO	

FOR WOMEN: *(please circle)*

Are you pregnant?	YES	NO	If yes, how many weeks pregnant are you? _____
Do you take any hormones or birth control?	YES	NO	*If yes, please list above with medications.*

FOR OFFICE USE ONLY

REVIEWED BY:

_____
Front Desk

_____
M.A. / Dr. / P.A.

____/____/____
Date

FOR OFFICE USE ONLY

This Form Was Completed By: *(please circle)*

Patient Responsible Party

_____ ___ ___ /___ ___/___ ___

SIGNATURE OF PATIENT / RESPONSIBLE PARTY **TODAY'S DATE**