



Medical History

Patient: _____ Date of Birth: ___/___/___ Today's Date: ___/___/___

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, list below:

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

- | | | |
|-----------|-----------|-----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |
| 10. _____ | 11. _____ | 12. _____ |

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

Lungs:	YES	NO	Urinary:	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infections when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal:	YES	NO
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea, Bleeding, Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:	YES	NO	Musculoskeletal:	YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint deformity	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Neurological:	YES	NO
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizure, Fainting	<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"/>	Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine:	YES	NO	Cancer History: _____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder: _____		
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (Type:) _____		
Menstrual Irregularities	<input type="checkbox"/>	<input type="checkbox"/>	Transplant: _____		

Surgeries/Procedures: _____

- Skin:** Have you ever had skin cancer? YES NO If yes, _____
- Has anyone in your family had skin cancer? YES NO
- Do you have a history of any specific skin diseases? YES NO If yes, _____
- Do you have problems with healing YES NO
- Do you develop keloids (scars) after surgery YES NO
- Do you bleed easily? YES NO
- Do you develop skin rashes in reaction to: Medications Food Environment Bandages Topical Neosporin Other

Social History:

- Occupation? _____ Hobbies? _____
- Do you drink alcohol? YES NO Do you smoke? YES NO
- Have you had or have you been exposed to HIV (AIDS) ? YES NO
- Are you pregnant? YES NO Due Date: ___/___/___ Breastfeeding? YES NO

Completed by: _____ / / _____
Signed by Patient Date

Updated / / _____ MA Init Updated / / _____ MA Init