MEDICAL HISTORY

Patient: ____________________________________ **Date of Birth:** ____/____/____ **Today's Date:** ____/____/____

Reason for today's visit: ____

How long have you had this problem? ______________________

Who referred you? ___ I have been a previous patient ___ Family or Friend _______________________________
(Name of family member or friend)

___ Our Website ___ Insurance plan ___ Yellow pages ___ Internet (Google, Yahoo, Yelp, etc.)

___Physician **Physician's name and address**: ____

Do you want a report sent to this physician? Y N

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

1. ___________________________ 3. ___________________________ 5. ________________________

2. ___________________________ 4. ___________________________ 6. ________________________

Please list any medications you are allergic to:____

Are you pregnant? Y N — Plan on becoming pregnant? Y N

Breastfeeding? Y N — Are you on birth control pills? Y N

Do you have now, or have you ever had any of the following: (Please circle YES or NO)

Respiratory:

Asthma	Y	N
Chronic Bronchitis	Y	N
Emphysema	Y	N
Hayfever	Y	N
Valley Fever	Y	N

Cardiovascular:

Bleeding Problems	Y	N
Heart Disease	Y	N
High Blood Pressure	Y	N

Gastrointestinal:

Ulcers	Y	N
Hepatitis B or C	Y	N

Other:

HIV	Y	N
Diabetes	Y	N
Blood Clots in Legs	Y	N
Hives	Y	N
History of Mental Illness	Y	N
Kidney Disease	Y	N
Tuberculosis	Y	N
Arthritis	Y	N

List any other diseases: ____________________

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Skin:

Have you ever had skin cancer? Y N Type __________________ When? ____________________

Has anyone in your family had melanoma skin cancer? Y N Who? ___________________________

Do you have a history of eczema (atopic dermatitis)? Y N

Has anyone in your family had ____ asthma ____ hay fever ____ eczema? Who? ___________________________

Do you develop skin rashes in reaction to ___ Bandages ___ Topical Neosporin (antibiotic) ___ Latex

Do you smoke? Y N Do you ever use a tanning bed/booth? Y N

Do you have a history of alcohol or substance abuse? Y N

Do you have any medical prosthetics, artificial valves, joints or pacemaker? Y N

Provider Signature ____ **Date** ____/____/____