



## Medical History

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

- Are you allergic to any prescription or non-prescription (pill or rub on) medications?

If yes, please give name(s). \_\_\_\_\_

- Do you have other allergies? Seasonal / Food / Other. If yes, please give name(s).

- List any medications you are currently taking (include vitamins, herbals, etc.).

### Medical History

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Abnormal scarring or keloids         | <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Liver Disease               |
| <input type="checkbox"/> Acne                                 | <input type="checkbox"/> Eczema                            | <input type="checkbox"/> Lupus                       |
| <input type="checkbox"/> Anemia                               | <input type="checkbox"/> Heart Attack                      | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Arthritis                            | <input type="checkbox"/> Hepatitis                         | <input type="checkbox"/> Psoriasis                   |
| <input type="checkbox"/> Asthma                               | <input type="checkbox"/> High Blood Pressure               | <input type="checkbox"/> Seizure Disorder            |
| <input type="checkbox"/> Blood Clots                          | <input type="checkbox"/> HIV+                              | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Congestive Heart Failure             | <input type="checkbox"/> Irregular Heart Beat (arrhythmia) | <input type="checkbox"/> Thyroid Disorder            |
| <input type="checkbox"/> Crohn's Disease / Ulcerative Colitis | <input type="checkbox"/> Joint Replacement                 | <input type="checkbox"/> Varicose Veins              |
| <input type="checkbox"/> Depression                           | <input type="checkbox"/> Kidney Disease requiring Dialysis | <input type="checkbox"/> Other _____                 |

Skin Cancer	<input type="radio"/> Y <input type="radio"/> N	Specify:
Malignant Melanoma	<input type="radio"/> Y <input type="radio"/> N	Specify:
Pre-cancerous Growths	<input type="radio"/> Y <input type="radio"/> N	Specify:

- Do you ever take aspirin, ibuprofen (Motrin, Advil), naproxen sodium (Aleve, Naprosyn), vitamin E supplements, garlic, ginger, ginkgo or ginseng supplements? If yes, please list items and describe how often.

## Medical History (continued)

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Develop rashes / reactions to bandages / tapes / antibiotic ointments	<input type="radio"/> Y <input type="radio"/> N
Require antibiotics prior to dental procedures	<input type="radio"/> Y <input type="radio"/> N
Tend to heal slowly or poorly	<input type="radio"/> Y <input type="radio"/> N
Use a tanning booth / bed	<input type="radio"/> Y <input type="radio"/> N
Wear contacts	<input type="radio"/> Y <input type="radio"/> N
Reaction to local or general anesthesia	<input type="radio"/> Y <input type="radio"/> N
Reaction to Epinephrine	<input type="radio"/> Y <input type="radio"/> N

### Past Surgical History

Abnormal Heart Valve	<input type="radio"/> Y <input type="radio"/> N
Artificial Heart Valve	<input type="radio"/> Y <input type="radio"/> N
Defibrillator	<input type="radio"/> Y <input type="radio"/> N
Dental Plates	<input type="radio"/> Y <input type="radio"/> N
Pacemaker	<input type="radio"/> Y <input type="radio"/> N
Artificial Joints _____	<input type="radio"/> Y <input type="radio"/> N
Organ Transplant _____	<input type="radio"/> Y <input type="radio"/> N

- List all major surgeries.

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### Skin Type

Is your skin easily irritated?	<input type="radio"/> Y <input type="radio"/> N
Do you tan easily?	<input type="radio"/> Y <input type="radio"/> N
Do you use sunscreen / sunblock? If yes, how often _____ what SPF? _____	<input type="radio"/> Y <input type="radio"/> N
Skin Type: <input type="radio"/> Normal <input type="radio"/> Oily <input type="radio"/> Dry <input type="radio"/> Combination	

- When exposed to the sun in the spring (first significant sun exposure of the warm season), do you?
  - ☐ Always Burn Never Tan (I)
  - ☐ Always Burn, Sometimes Tan (II)
  - ☐ Sometimes Burn, Always Tan (III)
  - ☐ Rarely Burn, Always Tan (IV)
  - ☐ Never Burn, Always Tan (V)

## Medical History (continued)

### Family History

Do any of your immediate family members (father, mother, siblings, child) have the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Abnormal Moles             | <input type="checkbox"/> Hair Loss             | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Acne                       | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Rosacea              |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Scarring             |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Skin Cancer          |
| <input type="checkbox"/> Bleeding Disorder          | <input type="checkbox"/> Lupus                 | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Blood Clots                | <input type="checkbox"/> Malignant Melanoma    | <input type="checkbox"/> Thyroid Disorder     |
| <input type="checkbox"/> Cancer _____               | <input type="checkbox"/> Multiple Miscarriages | <input type="checkbox"/> Vitiligo             |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Pre-Cancerous Growths | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Eczema (atopic dermatitis) | <input type="checkbox"/> Psoriasis             | _____   |

### Social History

Do you use tobacco? If yes, what type and how much? _____	<input type="radio"/> Y <input type="radio"/> N
Do you drink alcohol? If yes, how much in one week? _____	<input type="radio"/> Y <input type="radio"/> N
Do you use recreational drugs? If yes, what type and how much? _____	<input type="radio"/> Y <input type="radio"/> N
Do you use IV drugs? If yes, what type and how much? _____	<input type="radio"/> Y <input type="radio"/> N
What type of work do you do? _____	
Are you <input type="radio"/> single, <input type="radio"/> divorced, <input type="radio"/> married, <input type="radio"/> widowed?	

### For Females Only

Date of your last menstrual period _____	
Are your periods regular?	<input type="radio"/> Y <input type="radio"/> N
Are you menopausal?	<input type="radio"/> Y <input type="radio"/> N
Are you pregnant?	<input type="radio"/> Y <input type="radio"/> N
Are you breastfeeding?	<input type="radio"/> Y <input type="radio"/> N
What type of contraception (if any) is used? _____	

## Medical History (continued)

### Review of Symptoms

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Abdominal Pain    | <input type="checkbox"/> Excessive Stress        | <input type="checkbox"/> Muscle Pain / Weakness |
| <input type="checkbox"/> Abnormal Sweating | <input type="checkbox"/> Excessive Thirst        | <input type="checkbox"/> Nausea / Vomiting      |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Excessive Urination     | <input type="checkbox"/> Night Sweats           |
| <input type="checkbox"/> Bloody Stool      | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Palpitations           |
| <input type="checkbox"/> Chest Pain        | <input type="checkbox"/> Fluid Retention         | <input type="checkbox"/> Penile Discharge       |
| <input type="checkbox"/> Cough             | <input type="checkbox"/> Frequent Infections     | <input type="checkbox"/> Red Eyes               |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> Hair Loss               | <input type="checkbox"/> Shortness of Breath    |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Vaginal Discharge      |
| <input type="checkbox"/> Dry Eyes          | <input type="checkbox"/> Heartburn               | <input type="checkbox"/> Vision Problems        |
| <input type="checkbox"/> Dry Mouth         | <input type="checkbox"/> Heat / Cold Intolerance | <input type="checkbox"/> Weakness               |
| <input type="checkbox"/> Easy Bleeding     | <input type="checkbox"/> Hemorrhoids             | <input type="checkbox"/> Weight Change          |
| <input type="checkbox"/> Easy Bruising     | <input type="checkbox"/> Joint Pain or Swelling  | <input type="checkbox"/> Wheezing               |
| <input type="checkbox"/> Excessive Fatigue | <input type="checkbox"/> Joint Stiffness         |   |
| <input type="checkbox"/> Excessive Hunger  | <input type="checkbox"/> Leg Swelling            |   |

- Are there any other symptoms you would like to name? If yes, please list.

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\_\_\_\_\_  
Patient Signature

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Initial \_\_\_\_\_

\_\_\_\_\_  
Legal Representative Signature

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Initial \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Initial \_\_\_\_\_

Completed by ☐ Patient  
☐ Medical Assistant \_\_\_\_\_