Medical History

Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Allergies:**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications:**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician: First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred pharmacy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a flu shot? Yes No If yes, when? Month\_\_\_\_\_\_\_\_\_\_\_Day\_\_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_\_

Have you had a pneumonia shot? If yes, Month\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Year\_\_\_\_\_\_\_\_\_\_\_

**Past History:**

Lungs: Yes No Other Systemic : Yes No

Seasonal Allergies Diabetes

Asthma Thyroid If yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiovascular: Kidney If yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 High Blood Pressure Bladder If yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Irregular Heartbeat Gastrointestinal If yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Pacemaker Arthritis If yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Defibrillator Artificial Joints If yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Heart Attack Fainting If yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 High Cholesterol Anxiety/Depression

Do you bleed easily? Weakened Immune

System (Transplant,

Leukemia, etc.)

List any other diseases or conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hospitalizations or Surgical Procedures you have had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a reaction to local anesthesia in a physician or dental office? Yes No If yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin:**

Have you ever had any form of skin cancer? Yes No If yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Has anyone in your family had skin cancer? Yes No If yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you ever had any form of cancer? (ex: lung) Yes No If yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you have a history of any specific skin disease? Yes No If yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you have problems with healing? Yes No

 Do you develop keloids (scars) after surgery? Yes No

 Do you develop skin rashes in reaction to: Bandages Neosporin

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

 Do you drink alcohol? Yes No If yes, \_\_\_\_\_\_\_\_\_\_ drinks per day.

 Do you use IV drugs? Yes No If yes, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Smoking status Present \_\_\_\_\_\_packs per day Former Never

 Do you have a history of: HIV Hepatitis STDs None

 Are you pregnant, nursing or attempting to become pregnant? Yes No

What method do you use to prevent pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N/A

Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_