Patient Name: _____ Patient DOB: _____

MEDICAL HISTORY FORM

Name:	**Date:**

Drug Allergies:			
Medications/Dosage:			

Primary Care Physician: _____

Referring Physician: _____

Pharmacy of Choice/Location:	**Phone number:**

Medical History:

	Y	N		Y	N		Y	N
Abdominal Bleeding			Glaucoma			Psoriasis		
Arthritis			Heart Disease			Psychiatric Disorder		
Artificial Heart Valve			Heart Murmur			Radiation Therapy		
Artificial Joints			Hepatitis			Rheumatoid Arthritis		
Asthma			High Blood Pressure			Seasonal Allergies		
Autoimmune Disorder			High Cholesterol			Stroke		
Bleeding Disorder			HIV			Thyroid Disorder		
Blood Disease			Hives			Tuberculosis		
Cancer (non-skin)			HSV/cold sores			Ulcers		
Chemotherapy			Kidney Stones			Ulcerated Colitis		
Defibrillator			Migraines			Urinary Retention		
Diabetes			Mitral Valve Prolapse			OTHER:		
Eczema			Organ Transplant					
Epilepsy			Osteoporosis					
Fainting			Pacemaker					

Other Medical Conditions we should know about? _____
Other Skin Problems: _____
Family History of Hay Fever? ___Y ___N

Social History:

	Y	N	
Do you Smoke?			➡ If Yes, how much?
Do you drink Alcohol?			➡ If Yes, how much?
Have you ever been exposed to HIV (AIDS)?			

	Y	N		Y	N		Y	N
Are you pregnant?			Do you bleed easily?			Any artificial joints?		
Any family history of skin cancer?			Have you ever had Lidocaine (Anesthetic)?			Did you have a bad reaction?		

← FORM CONTINUES ON OPPOSITE SIDE →

Patient Name: _____ Patient DOB: _____

Review of Symptoms:

	Y	N		Y	N		Y	N
Weight Loss			Shortness of Breath			Mood Swings		
Eye Problems			Headaches			Numbness/Tingling		
GI Abnormality			Fever			Muscle Aches		
Dysuria			Heat/Cold Intolerance			Vision Changes		
Joint Pain			Irregular Periods			OTHER:		
Chest Pain			Weakness/Malaise					

Past Surgeries:

Operation	*Date*

Skin History:

	Y	N
Do you have a history of thickened scars or keloid scars?		
Do you have a history of precancerous lesions?		
Have you ever had skin cancer? If so, please describe:		
Any personal or family history of melanoma?		
When in the sun, do you: Burn then Tan?		
Tan only?		
Burn only?		

What is your occupation? _____
What are your hobbies? _____

Patient Signature: _____ Date: _____

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