

Medical History Form

Instructions: Fill in the blanks and circle yes or no where indicated.

Name _____ Date of Birth _____ Age _____

Occupation _____ Family Physician _____ Referred by _____

REASON FOR SEEKING MEDICAL CONSULTATION? _____

WEIGHT? Now _____ One year ago _____ Maximum _____ When _____ HEIGHT _____

Have you ever smoked? yes no Do you smoke now? yes no If yes # of packs/day _____ How long? _____

When did you quit smoking? _____

Do you use chewing tobacco? yes no Have you ever used chewing tobacco? yes no

Do you drink alcohol? yes no How much do you drink a day? _____ Have you ever used alcohol heavily? Yes no

Have you ever used or been addicted to any drug or medication? yes no; explain _____

FAMILY HISTORY:

Has any blood relative ever had: If yes, which relative?

Melanoma.....No Yes

Tuberculosis..... No Yes

Diabetes..... No Yes

Heart Trouble.....No Yes

High Blood Pressure.....No Yes

Stroke.....No Yes

Epilepsy..... No Yes

Vascular Disease..... No Yes

Hearing Loss.....No Yes

Patient ALLERGIES:(Circle, describe YOUR reaction)

Penicillin _____

Sulfa _____

Cephalosporins _____

Mycins _____

Tetracyclines _____

Iodine _____

Adhesive Tape _____

IVP Dye _____

Aspirin _____

Codeine _____

Morphine _____

Demerol _____

Quinolone _____

Other _____

Systems History and Review of symptoms (circle if positive):

Have you ever had or do you now have(circle yes or no) & describe:

Psychiatric Treatment/complaints/depressed..... No Yes

Heart disease/chest pain/palpitations/pacemaker/AICD...No Yes

Kidney Disease/Nephritis/urinary problems/dialysis/pain..No Yes

Liver Disease/hepatitis/yellow skin.....No Yes

Respiratory/lung:problem breathing/cough/noisy/asthma.No Yes

Neurologic/Stroke/weak/tingling/imbalance/dizzy/falls.....No Yes

Hematologic:anemia/bleeding/heavy period/slow clotting.No Yes

Endocrine:Diabetes/thirst/sweats/fatigue/weight change..No Yes

Gastrointestinal/Ulcers/Bowel prob/diarrhea/nausea/vomitNo Yes

Snoring/awaken tired/morning headaches.....No Yes

Vision problems /Glaucoma/blurring/pain eyes.....No Yes

Trouble with bleeding.....No Yes

Cancer / where _____ No Yes

High Blood Pressure.....No Yes

Tuberculosis.....No Yes

Risk or + Immune def/transplant/HIV/chemo.....No Yes

Skin: rash/itching/sores.....No Yes

Hay Fever/itchy:eyes,nose,sneezing/blocked nose,.....No Yes

Musculoskeletal: muscle/back/neck/joint pain..... No Yes

Frequent Infections.....No Yes

Type/location _____

Rheumatic Fever/heart murmurNo Yes

Other Diseases/complaints/problems _____ No Yes

Explain all yes answers: _____

Have you ever been hospitalized? Yes No If Yes, please explain _____

ANY OTHER MEDICAL PROBLEMS: _____

Have you ever had an abnormal Electro-Cardiogram (EKG)? Yes No , Give details: _____

Last menstrual period: _____ Are you or is there a chance you are pregnant? No Yes Due Date _____

Have you been diagnosed with sleep apnea? _____ What is current treatment for apnea _____

Medications (prescribed or over the counter):

Name Dosage # of times a day

Circle: Vitamins,Herbals,Aspirin,Ibuprofen, arthritis meds? _____

Have you ever had:

Hyperpigmentation (dark spots) no yes

Excessive sun exposure.....no yes

Fever Blisters.....no yes

Dermabrasion.....no yes

Chemical Peels....no yes..type _____

Facial fillers/inject? Yes no type _____

Accutane no yes; last dose when _____

Retin A.....no yes

Steroids ("prednisone")....no yes

Facial...no yes type _____

Botox yes no when last _____

Bad Scarring.....no yes

Radiation to head or face..no yes

Surgeries (list all):

Type Year

Fitzpatrick Skin Type

(circle one)

1 very white + always burns

2 white + usually burns

3 white-olive + sometimes burns

4 brown + rarely burns

5 dark brown + very rarely burns

6 black + never burns

For Staff Use: Photoaging

wrink kerat makeup

mild little none none

mod early earl little

adv persist many always

severe severe cancer? poor

cover

By signing here, I certify that the above is true and complete. I agreed to inform the office of any changes of this form.

Patient Signature _____ Date _____

Updated 5/18/18 Staff review front office NAME _____ DATE _____

rdk review _____ DATE _____

Staff review clinical area NAME _____ DATE _____

Filed STAFF NAME _____ DATE _____