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 murmur ……No 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? _____

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

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

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_____ Staff review clinical area NAME_____DATE_____
rdk review _____DATE_____ Filed STAFF NAME_____DATE_____