Medical History

Patient's Name:____ Date:______________________

Reason for today's visit:____

List all medications you are currently taking:

1.____________________________ 2.___________________________ 3.__________________________

4.____________________________ 5.___________________________ 6.__________________________

Are you allergic to any medication? **YES** **NO** If yes, please list:

1.____________________________ 2.___________________________ 3.__________________________

Do you have or have you ever had diseases or conditions of the following:

Lungs:	**YES**	**NO**	***Other Systemic:***	**YES**	**NO**	***Vascular:***	**YES**	**NO**
Bronchitis			Diabetes			High Blood Pressure		
Emphysema			Thyroid			Heart Attack		
Asthma			Kidney			Heart Murmur		
Chronic Cough			Bladder			Irregular Heart Beat		
Morning			Stomach			Pacemaker		
			Bowel			Phlebitis		
			Hepatitis					
			Glaucoma					
			Arthritis					
			Convulsions, Epilepsy or Seizures					
			Fainting					

Do you drink alcohol? YES NO If YES _________drinks per day.

Do you use IV drugs: YES NO If YES, what?________________ How much?_____________________

Have you had or have you ever been exposed to HIV (AIDS)? YES NO

Have you ever had dental anesthesia (Novocain)? YES NO Any bad reaction? YES NO

Do you need to take antibiotics prior to having dental procedures or other surgical procedures? YES NO

Skin:

Would you be interested in a complementary skin care consultation with our aesthetician? YES NO

When you are exposed to the sun do you: Tan only Tan and burn Burn

Have you ever had skin cancer YES NO What type?________________________________

Has anyone in your family ever had skin cancer? YES NO Who and what type?_______________________

Do you have a history of any skin diseases? YES NO

If yes, please list:____

List any other diseases or conditions we should know about:____

List any surgical procedures you have had in the last 6 months:______________________________________

Do you smoke? YES NO If yes, how much:___________________________________

Do you bleed easily? YES NO

Are you pregnant or breastfeeding? YES NO If yes, due date:___________________________________

Do you have artificial joints? YES NO

What is your occupation:_________________________________What are your hobbies:______________________

Completed by: Patient ____

Medical Assistant Medical Assistant Signature Date