

MEDICAL HISTORY

Date _____

Patient _____

Are you allergic to any medications? (circle)

YES

NO

If YES please list:

List any medications you are presently taking:

Do you now have, or have you ever had diseases or conditions of :

	YES	NO	Family History
Lungs	_____	_____	_____
Asthma	_____	_____	_____
High Blood Pressure	_____	_____	_____
Heart Attack	_____	_____	_____
Heart Murmur	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid	_____	_____	_____
Kidney	_____	_____	_____
Liver	_____	_____	_____
Arthritis	_____	_____	_____
Epilepsy / Seizures	_____	_____	_____
Lupus	_____	_____	_____
Infertility	_____	_____	_____
HIV	_____	_____	_____
Hepatitis C	_____	_____	_____
Seasonal Allergies / Hayfever	_____	_____	_____
Cancer (type) _____	_____	_____	_____

Other Serious Illness or Surgery:

Do you now have, or have you ever had any of the following skin conditions:

	YES	NO	Family History
Eczema	_____	_____	_____
Psoriasis	_____	_____	_____
Melanoma	_____	_____	_____
Other Non-melanoma skin cancer	_____	_____	_____
Other skin conditions	_____	_____	_____
Do you smoke?	_____	_____	
Do you drink alcohol?	_____	_____	
# drinks per day _____			
Any history of X-ray therapy	_____	_____	
Any artificial heart valves, pacemaker or defibrillator			

(Circle which apply)

Have you ever been told to take antibiotics
prior to surgery or dental work? _____

FEMALES ONLY (Circle which apply)

Menstrual Periods:

None Regular Irregular Menopause

Are you on?

Birthcontrol/Patch DeproProvera IUD

Are you currently ?

Pregnant Breast Feeding

If pregnant, what is the due date? _____

Please Sign

Patient / Guardian _____

Date: _____

Physician Signature: _____

Date: _____