MEDICAL HISTORY

Patient_____Patient Date of Birth_____Phone #_____

Address_____ City_____ State_____ Zip_____

Reason for Today's Visit_____ Referring Doctor_____

Are you allergic to any medications? Yes No If yes, please list_____

Have you ever had dental anesthesia(Novocain)? Yes No Any bad reactions Yes No

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1._____ 2. _____ 3. _____

4._____ 5. _____ 6. _____

Do you have now, or have you ever had diseases or condition of: (Please check yes or no)

Lungs:	**Yes**	**No**
Bronchitis	○	○
Emphysema	○	○
Asthma	○	○
Chronic Cough	○	○
Morning Cough	○	○
Shortness of Breath	○	○
Wheezing	○	○
Cardiovascular	○	○
High Blood **Pressure**	○	○
Chest Pain	○	○
Heart Attack	○	○
Irregular Heartburn	○	○
Heart Murmur	○	○
Phlebitis	○	○
Inflammation of Vein	○	○
Blood Clot	○	○
Pacemaker	○	○

Other Systemic:	**Yes**	**No**
Diabetes	○	○
Excessive Thirst/Hunger	○	○
Amputation	○	○
Thyroid	○	○
Kidney	○	○
Dialysis	○	○
Bladder	○	○
Frequency/Burning	○	○
Gastrointestinal	○	○
Stomach Absorptive Disorder	○	○
Nausea, vomiting, diarrhea	○	○
when taking antibiotics	○	○
Yeast infection	○	○
taking antibiotics	○	○
Arthritis/Joint Deformity	○	○
Arthralgia	○	○
Limited Motion	○	○
Artificial Joint	○	○
Convulsions, Epilepsy or Seizures	○	○
Fainting	○	○

List any other diseases or conditions_____

List any surgical procedures you have had in the last 6 months_____

Skin: Have you ever had skin cancer? _____ Do you bleed easily?

Has anyone in your family had skin cancer? _____ Do you have problems with healing?

Do you develop keloids (raised scars) after surgery? _____ Do you have a history of specific skin disease? _____ If yes, explain_____

Do you develop skin rashes in reaction to Medications _____ Food _____ Environment _____ Bandages _____ Neosporin_____

Other_____

Social History:	Yes	No	
Do you drink alcohol?	○	○	If yes, _____drinks per day
Do you use IV drugs?	○	○	If yes, what_____ How Often? _____
Do you smoke/vape?	○	○	If yes, how much? _____

Please Answer the following questions

(Women) Are you pregnant? Yes No Due Date_____/_____/_____

What is your occupation**?** _____ Hobbies? _____

Do we have permission to discuss your medical condition with family members? Yes No

If so, name_____ Relationship_____

Completed by: Patient/Guardian Signed by Patient_____ Date _____/_____/_____

Medical Assistant_____

Initials Reviewed by_____ Date_____/_____/_____