

# PATIENT MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Understanding your health history is very important to us in treating your health problems. Please take the time to fully and completely fill out the information below. If you have any questions or any of the questions need clarification, please ask us. (*Briefly explain any "yes" answers*)

1. Who is your family physician? \_\_\_\_\_

2. What is your occupation? \_\_\_\_\_

3. List any medications for skin problems. \_\_\_\_\_

4. List any other medications you are currently taking including nonprescription items, vitamins and herbal supplements:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Do you take blood thinners, coumadin, aspirin, Plavix or Warfarin? \_\_\_\_\_ Yes \_\_\_ No \_\_\_

6. Do you have a **PACEMAKER** and/or **DEFIBRILLATOR**? \_\_\_\_\_ Yes \_\_\_ No \_\_\_

7. Are you allergic to any medications? \_\_\_\_\_ Yes \_\_\_ No \_\_\_

If yes, please list medications \_\_\_\_\_

8. Any allergies to other substances? (food, plants, etc.?) \_\_\_\_\_ Yes \_\_\_ No \_\_\_

If yes, please list all allergies \_\_\_\_\_

9. Have you had skin cancer? \_\_\_\_\_ Yes \_\_\_ No \_\_\_

If so, what type(s) \_\_\_\_\_

10. Do you have a personal history of internal cancer? \_\_\_\_\_ Yes \_\_\_ No \_\_\_

11. Any family members with skin cancer? \_\_\_\_\_ Yes \_\_\_ No \_\_\_

If so, what type(s)? \_\_\_\_\_

12. Any moles changing recently? (color, size, bleeding) \_\_\_\_\_ Yes \_\_\_ No \_\_\_

13. Have you been treated for skin problems in the past? \_\_\_\_\_ Yes \_\_\_ No \_\_\_

14. Sinus trouble, asthma, hay fever, allergies or other ear, nose, throat or mouth problems? \_\_\_\_\_ Yes \_\_\_ No \_\_\_

15. Do you have any urinary tract or kidney problems? \_\_\_\_\_ Yes \_\_\_ No \_\_\_

16. Have you ever had any organ transplant? \_\_\_\_\_ Yes \_\_\_ No \_\_\_

If yes, what organ and what medications for transplant rejection are you receiving? \_\_\_\_\_

\_\_\_\_\_

17. Are you at high risk for HIV infection or HIV positive? \_\_\_\_\_ Yes \_\_\_ No \_\_\_

18. Do you smoke? \_\_\_\_\_ Yes \_\_\_ No \_\_\_

19. Do you drink alcohol? \_\_\_\_\_ Yes \_\_\_ No \_\_\_

20. Do you have any pets/animals at home? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

What type? \_\_\_\_\_

21. Do you have any heart or vascular disease? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

22. Have you ever had a blood transfusion? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

23. Have you ever had intestinal disease, liver (hepatitis) or kidney problems? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

24. Have you ever had respiratory problems, tuberculosis or any other lung disease? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

25. Have you ever had diabetes, thyroid or other endocrine problems? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

26. Have you ever had lupus, arthritis or other connective tissue/rheumatologic disease? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

27. Have you ever had any blood or bleeding problems? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

28. Do you have a history of psychiatric illness and/or depression? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

29. Have you ever had epilepsy (seizures), myasthenia gravis or other neurological disease? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

30. Have you had a recent weight loss? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

31. Have you had any eye problems? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

32. Have you had any recent major surgeries or been hospitalized? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

33. Have you had any of the following cardiovascular diseases or problems? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

Please circle any of the following that apply (heart attack, angina, heart murmur, arteriosclerosis, rheumatic heart disease, stroke, high blood pressure, damaged or artificial heart valves, open heart surgery, stents, blood clots)

34. Are you pregnant, nursing or planning to get pregnant within the next 6 months? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

35. Are you on any form of birth control? \_\_\_\_\_ Yes\_\_\_ No\_\_\_

If so, what type? \_\_\_\_\_

**SIGNED BY ALL PATIENTS**

The above information is true and correct to the best of my belief.

Patient/Authorized Representative Signature:

\_\_\_\_\_

Date: \_\_\_\_\_

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**OFFICE USE ONLY**

Reviewed by Doctor/Physician Assistant

Signature:

\_\_\_\_\_

Date: \_\_\_\_\_