

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 you are currently taking including nonprescription items, vitamins and herbal supplements:

4. Do you take blood thinners, coumadin, aspirin, Plavix, Warfarin? Yes___ No___

5. Do you have a **PACEMAKER** and/or **DEFIBRILLATOR**? Yes___ No___

6. Are you allergic to any medications?

If yes, please list _____ Yes___ No___

7. Any allergies to other substances? (food, plants, etc.?)

If yes, please list _____ Yes___ No___

8. Have you had skin cancer? If so, what type(s) Yes___ No___

9. Do you have a personal history of internal cancer?..... Yes___ No___

10. Any family members with skin cancer / melanoma?..... Yes___ No___

11. Any moles changing recently? (color, size, bleeding) Yes___ No___

12. Have you been treated for skin problems in the past? Yes___ No___

13. Sinus trouble, asthma, hay fever, allergies, or other ear, nose, throat or mouth problems?..... Yes___ No___

14. Do you have any urinary tract or kidney problems?..... Yes___ No___

15. Have you ever had an HIV test? Yes___ No___

19. Are you at high risk for HIV infection or HIV positive?..... Yes___ No___

20. Have you ever had tuberculosis? Yes___ No___

21. Do you smoke? Yes___ No___

22. Do you drink alcohol?..... Yes___ No___

23. Do you have any heart or vascular disease? Yes___ No___
24. Have you ever had a blood transfusion?..... Yes___ No___
25. Have you ever had intestinal disease or liver problems? (hepatitis)..... Yes___ No___
26. Have you ever had respiratory problems, or lung disease? Yes___ No___
27. Have you ever had thyroid or other endocrine problems?..... Yes___ No___
28. Have you ever had arthritis? Yes___ No___
29. Have you ever had lupus or other connective tissue disease? Yes___ No___
30. Have you ever had any blood or bleeding problems?..... Yes___ No___
31. Do you have a history of psychiatric illness and/or depression?..... Yes___ No___
32. Have you ever had epilepsy (seizures) myasthenia gravis or other neurological disease?..... Yes___ No___
33. Have you ever had diabetes or elevated blood sugar? Yes___ No___
34. Have you had recent weight loss?..... Yes___ No___
35. Have you had eye problems?..... Yes___ No___
36. Have you had problems with ears, nose, mouth or throat?..... Yes___ No___
37. Have you had any recent major surgeries or been hospitalized? Yes___ No___
38. Have you had any of the following cardiovascular diseases or problems? Please circle correct diagnosis Yes___ No___
 (heart attack, angina, heart murmur, arteriosclerosis, rheumatic heart disease, stroke, high blood pressure,
 damaged or artificial heart valves, open heart surgery, stents, blood clots)
39. Are you pregnant or nursing? Yes___ No___
41. Are you taking birth control pills?..... Yes___ No___

SIGNED BY ALL PATIENTS

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

Patient/Authorized Representative Signature:

Date: _____

OFFICE USE ONLY
 Reviewed by Doctor/Physician Assistant

Signature:

Date: _____