MEDICAL HISTORY

Patient's Name: _____ Date: _____

Are you allergic to any medications? ☐ Yes ☐ No *If yes, please list* _____
Have you had any reaction to anesthesia? ☐ Yes ☐ No *If yes, explain* _____
Do you require prophylaxis antibiotics? ☐ Yes ☐ No
Who is your Primary Care Physician? *List Name, Address & Phone #:* _____
_____

Do you have now, or have ever had diseases or conditions of: (*please check* yes or no) ?

Yes	No	ENT
☐	☐	Glaucoma
☐	☐	Itchy eyes
☐	☐	Ear infections
☐	☐	Sinus Trouble
☐	☐	Nosebleeds
☐	☐	Mouth sores
☐	☐	Other: _____

RESPIRATORY

☐	☐	Shortness of Breath
☐	☐	Wheezing
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Other: _____

CARDIOVASCULAR

☐	☐	Chest pain
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Irregular heartbeat
☐	☐	Heart attack
☐	☐	Heart murmur
☐	☐	Cardiac surgery
☐	☐	Mitral valve prolapse
☐	☐	Artificial heart valve
☐	☐	Pacemaker
☐	☐	Phlebitis (inflammation of veins)
☐	☐	High Cholesterol
☐	☐	Other _____

GASTROINTESTIONAL

☐	☐	Heartburn
☐	☐	Ulcers
☐	☐	Liver disease/Hepatitis
☐	☐	Gallstones
☐	☐	Irritable bowel
☐	☐	Other _____

Yes	No	GENITOURINARY
☐	☐	Incontinence
☐	☐	Frequent Urination
☐	☐	Kidney Stones
☐	☐	Dialysis

Age of Menopause _____
Age periods started _____
Frequency of periods _____

☐	☐	Other _____

Yes	No	MUSCULOSKELETAL
☐	☐	Chronic back pain
☐	☐	Osteoarthritis
☐	☐	Pain in calves
☐	☐	Rheumatoid arthritis
☐	☐	Lupus
☐	☐	Artificial joints _____
☐	☐	Other _____

NEUROLOGIC

☐	☐	Fainting or loss of consciousness
☐	☐	Seizures/Convulsions/Epilepsy
		Explain _____
☐	☐	Stroke
☐	☐	Migraine/frequent headaches
☐	☐	Alzheimers disease
☐	☐	Other _____

HEMATOLOGIC

☐	☐	Swelling of feet/ankles
☐	☐	Phlebitis/painful veins
☐	☐	Varicose veins
☐	☐	Blood clots
☐	☐	Frequent or excessive bleeding
☐	☐	Bleeding after surgery
☐	☐	Blood disease
☐	☐	Taking blood thinners
☐	☐	Other _____

ENDOCRINE

☐	☐	Diabetes mellitus
☐	☐	Thyroid disease, type _____
☐	☐	Other _____

SKIN

☐	☐	Skin Cancer _____
☐	☐	Problems with healing
☐	☐	Bleed easily
☐	☐	Keloids scars
☐	☐	Slow in healing
☐	☐	Develop rashes in reaction to: ☐ Medications ☐ Food ☐ Environment
		Explain: _____
☐	☐	Other _____

MEDICAL HISTORY
Cont page 2

Patient's Name: _____ **Date:** _____

Yes	No	PSYCHIATRIC
☐	☐	Stress/anxiety
☐	☐	Mood swings
☐	☐	Depression
☐	☐	Thoughts of suicide
☐	☐	Other _____

MALIGNANCY

☐ ☐ Cancer types, past/present

_____

☐ ☐ Chemotherapy dates

_____

INFECTIONS

☐ ☐ Fever blisters
☐ ☐ Herpes, location _____
☐ ☐ Shingles
☐ ☐ Chickenpox
☐ ☐ Hepatitis
☐ ☐ Tuberculosis
☐ ☐ HIV
☐ ☐ Other _____

SOCIAL HISTORY

☐ ☐ Do you drink alcohol? *If yes,* _____drinks per day _____ per week
☐ ☐ Do you use IV drugs? *If yes, what?* _____ *How often?* _____
☐ ☐ Do you smoke? *If yes, how much?* _____
☐ ☐ Exercise regularly

FAMILY HISTORY

☐ ☐ Do any 1st degree relative *(father, mother, brother, sister)* have skin cancer? _____
☐ ☐ Do any 1st degree relative have cancer? _____
☐ ☐ Other _____

SURGERIES

List surgeries, including cosmetic

Type	*Date*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Completed by: ☐Patient ☐Medical Assistant _____*(initials)*

Signature of Patient: _____ Date: _____

Questionnaire reviewed by: DR._____