MEDICAL HISTORY

Patient:____________________________________

Reason for today's visit(chief complaint):____
How long have you had symptoms?____
What treatment have you used, if any?____
List all medications you are currently taking: 1.____________________________ 2.____________________________
3.____________________________ 4.____________________________ 5.____________________________
Height:__________ Weight:__________

Past Medical History

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

SKIN:	Yes	No
Skin cancer:	❑	❑
Lupus	❑	❑
Psoriasis	❑	❑
Autoimmune	❑	❑

If yes, type?__________
Treatment?__________

Other skin disorders:__________________
Treatment:____________________________
When exposed to the sun do you: ❑Tan ❑Tan and Burn ❑Burn

LUNGS:	Yes	No
Bronchitis:	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑

VASCULAR:	Yes	No
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heart Beat	❑	❑
Pacemaker	❑	❑
Phlebitis	❑	❑

Review of Symptoms

Other Symptoms:	Yes	No
Diabetes	❑	❑
Kidney	❑	❑
Stomach	❑	❑
Hepatitis or Yellow Skin	❑	❑
Arthritis/Joint deformity	❑	❑
Fainting	❑	❑

Other Symptoms:	Yes	No
Thyroid	❑	❑
Bladder	❑	❑
Bowel	❑	❑
Glaucoma	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑

Surgical History(list any surgeries):____________________________
Any other diseases you may have__________________
Allergies: Are you allergic to any medications? ❑Yes ❑No If yes, please list____________________________

Family History

Anyone in your family ever have skin cancer? ❑Yes ❑No Who?__________ Type?__________
Any family history of Skin or Autoimmune disorders? ❑ Yes ❑No Who?__________ Type?__________
Any other pertinent family skin condition or diseases? ❑Yes ❑No Who?__________ Type?__________

Social History

A. Do you smoke? ❑ Yes ❑No If Yes, how much?__________________
B. Do you bleed easily? ❑Yes ❑No C. Do you have artificial joint(s) ❑Yes ❑No
D. Do you drink alcohol? ❑ Yes ❑ No If Yes_____drinks per day.
E. Do you use IV drugs? ❑Yes ❑No If Yes, what?__________________ How much?__________
F. Have you ever had dental anesthesia (Novocaine)? ❑ Yes ❑No Any bad reaction? ❑ Yes ❑ No
G.(Women)Are you pregnant? ❑Yes ❑No Due date:__________________
H. What is your Occupation?____________________________
I. What are your hobbies?____________________________

Completed by: Patient__________________ Reviewed by:____________________________
Medical Assistant__________ Signed by physician Date