

# MEDICAL HISTORY

CHART # \_\_\_\_\_

Please thoroughly complete this history form to help ensure the best possible medical treatment.

Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Reason for visit:** \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

What treatment have you used on your own? \_\_\_\_\_

What prescription treatments have been used? \_\_\_\_\_

Are you **ALLERGIC TO ANY MEDICATIONS**? If so, please list: \_\_\_\_\_

List any **medications** you are **currently taking** and circle the approximate **length of time** that you have been on the medication:

- |          |                    |           |                   |
|----------|--------------------|-----------|-------------------|
| 1) _____ | less than one year | 1-5 years | more than 5 years |
| 2) _____ | less than one year | 1-5 years | more than 5 years |
| 3) _____ | less than one year | 1-5 years | more than 5 years |
| 4) _____ | less than one year | 1-5 years | more than 5 years |
| 5) _____ | less than one year | 1-5 years | more than 5 years |

\*\*If you are taking more than 5 medications, please continue on the back of this form.

Have you had **aspirin or ibuprofen** in the last two weeks?  yes  no

Have you ever had **dental anesthesia** (novocaine)?  yes  no

If yes, any bad reactions? \_\_\_\_\_

Do you smoke?  yes  no If yes, how much? \_\_\_\_\_

Do you drink alcohol?  yes  no If yes, how many drinks per day? \_\_\_\_\_

Do you use IV drugs?  yes  no If yes, what kind? \_\_\_\_\_

Have you ever had or been exposed to HIV (AIDS)?  yes  no

Have you ever had or been exposed to Hepatitis?  yes  no

When you are exposed to the sun do you:  Tan only  Tan and Burn  Burn

Have **you** ever had **skin cancer**?  yes  no If yes, was it melanoma? \_\_\_\_\_

Has a **family member** had **skin cancer**?  yes  no

If yes, was it **melanoma**?  yes  no If yes, whom? \_\_\_\_\_

Do you have a history of any specific **skin diseases**?  yes  no

If yes, please list the type: \_\_\_\_\_

Do you have artificial joints?  yes  no

Do you bleed easily?  yes  no

Do you faint easily?  yes  no

(Women) Are you Pregnant?  yes (due date) \_\_\_\_\_  no

What is your occupation? \_\_\_\_\_

What are your hobbies: \_\_\_\_\_

What **blood relative** has:

Diabetes \_\_\_\_\_ Asthma \_\_\_\_\_ Hay fever \_\_\_\_\_

Skin disease \_\_\_\_\_ What type? \_\_\_\_\_

Do **you** have any of the following conditions?

Diabetes \_\_\_\_\_ Asthma \_\_\_\_\_ Hay fever \_\_\_\_\_ Heart disease \_\_\_\_\_

Lung disease \_\_\_\_\_ Stomach ulcers \_\_\_\_\_ High blood pressure \_\_\_\_\_