

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

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Reason(s) you're seeing the doctor: \_\_\_\_\_

Symptoms and past treatments: \_\_\_\_\_

\_\_\_\_\_

Past Health History: (use "c" for current and "p" for previous)

- Allergies/Hay Fever
- Anemia
- Arthritis
- Asthma
- Bleeding disorder
- Cancer
- Diabetes
- Glaucoma
- Heart disease
- Heart murmur
- Hepatitis
- Herpes
- High blood pressure
- High Cholesterol
- HIV
- Joint Problems
- Kidney disease
- Liver disease
- Lupus
- Pacemaker
- Stomach ulcers
- Stroke
- Thyroid Disease
- Other \_\_\_\_\_

Skin Disease:

- Eczema
- Atypical moles
- Psoriasis
- Scars/Keloids
- Skin Cancer: \_\_\_\_\_ Location \_\_\_\_\_
- Basal Cell \_\_\_\_\_
- Melanoma \_\_\_\_\_
- Squamous Cell \_\_\_\_\_
- Other \_\_\_\_\_

Current Medications

(List type, dose and date started, including birth control, OTC and topical medications)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

Allergies  
Drug Allergies

- Anesthetics
- Codeine
- Penicillin
- Tetracycline
- Novocain
- Food
- Latex
- Aspirin
- Erythromycin
- Sulfa
- Lidocaine
- Other \_\_\_\_\_
- Tape
- Other \_\_\_\_\_

Non-Drug Allergies

Surgeries

(list previous surgeries/dates)

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Family Health History: (please identify relatives (mother, father, siblings) that have had the following conditions)

<u>Disease</u>	<u>Relative(s)</u>	<u>Disease</u>	<u>Relative(s)</u>
Allergies	_____	Heart disease	_____
Arthritis	_____	High blood pressure	_____
Asthma	_____	Malignant melanoma	_____
Cancer	_____	Other skin cancer	_____
Diabetes	_____	Psoriasis	_____
Eczema	_____		

Social History: (check all that apply)

- Do you smoke? \_\_\_\_\_ No \_\_\_\_\_ Yes Frequency \_\_\_\_\_
- Do you drink alcohol? \_\_\_\_\_ No \_\_\_\_\_ Yes Frequency \_\_\_\_\_
- Do you use recreational drugs? \_\_\_\_\_ No \_\_\_\_\_ Yes Frequency \_\_\_\_\_
- Do you live alone? \_\_\_\_\_ No \_\_\_\_\_ Yes
- What is your occupation? \_\_\_\_\_
- What are your hobbies? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Reviewed By \_\_\_\_\_ Date \_\_\_\_\_

Completed by: \_\_\_ Patient \_\_\_ Medical Assistant