**PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY FORM**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age\_\_\_\_\_\_ Sex □M □F Referred by: □ M.D.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □self/friend \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON for today’s visit: (chief complaint)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATION ALLERGIES □None List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT MEDICATION \*\*Including over the counter products + vitamins\*\*

□None List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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MEDICAL HISTORY Current or past problems with:

□ **NONE OF THE BELOW** **SKIN PROBLEMS** □ NONE

□ HEARING PROBLEMS □IRREGULAR MENSES □ECZEMA □PSORIASIS □RASH

□GLAUCOMA □CATARACTS □CHLAMYDIA □GONNORHEA □ABNORMAL MOLES □HIVES

□NOSE BLEEDS □SINUS TROUBLE □RECENT WEIGHT LOSS □FREQUENT SUN EXPOSURES

□HOARSENESS □HAY FEVER □ANEMIA □BRUISE EASILY □EXCESSIVE SCARRING

□ASHTMA □HYPERTENSION □CANCER □OTHER SKIN CANCER

□CORONARY HEART DISEASE □PACEMAKER □DIABETES □THYROID DISEASE □MELANOMA

□HEART MURMUR □ARTIFICIAL HEART VALVE □SEIZURE □STROKES □RECENT OR PROGRESSIVE HAIR LOSS

□PALPITATIONS □IRREGULAR PULSE □MIGRAINE HEADACHES □PRECANCER SPOTS (ACTINIC KERATOSIS)

□VARICOSE VEINS □PHLEBITIS □ARTHRITIS □GOUT

□DIFFICULTY SWALLOWING □HEARTBURN □MENTAL ILLNESS □DEPRESSION

□PEPTIC ULCER DISEASE □COLITIS □TUBERCULOSIS □HIV/AIDS

□JAUNDICE □HEPATITIS □ALLERGIES (NON-DRUG)

□KIDNEY STONES □PROSTATE PROB. □OTHERS (EXPLAIN)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□VENEREAL DISEASE □HERPES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOSPITAL ADMISSIONS Indicate the year you were admitted to hospital and the reason. Do not include normal pregnancies

|  |  |  |  |
| --- | --- | --- | --- |
| YEAR | ILLNESS OR OPERATION | YEAR | ILLNESS OR OPERATION |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Females: are you pregnant? \_\_\_yes \_\_\_no Planning to become pregnant? \_\_\_\_yes \_\_\_no

On Birth Control Pill? \_\_\_\_yes \_\_\_no

FAMILY HISTORY □ NONE

□ MELANOMA □ECZEMA □DIABETES

□OTHER SKIN CANCER □HAY FEVER □CANCER

□PSORIASIS □ASTHMA □OTHERS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL HISTORY Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear: □ DENTURES □GLASSES □CONTACT LENSES MARITAL STATUS: □S □M □D □W

Smoking: □ No □ Former □Yes: How many packs/day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol: □ No □ Social/Occasional drinking only

Alcohol or drug problems/addictions: □ No □describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONFIRMED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Office use only]

(MD Signature)