Medical History Form

Patient_________________________ Date of Birth_____/_____/_____ Today's Date_____/_____/_____
Reason for Visit____
Are you allergic to any medications? ☐ Yes ☐ No If yes, which?______________________________
What medications are you taking? ____

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

	Yes	No		Yes	No
COPD	☐	☐	Diabetes	☐	☐
Emphysema	☐	☐	Lupus	☐	☐
Asthma	☐	☐	Amputation	☐	☐
Hearing Problems	☐	☐	Thyroid	☐	☐
Stroke	☐	☐	Kidney problems	☐	☐
Cancer	☐	☐	Dialysis	☐	☐
Any Organ Transplant	☐	☐	Bladder problems	☐	☐
Depression	☐	☐	Dementia	☐	☐
High Blood Pressure	☐	☐	Gastrointestinal	☐	☐
Rheumatic Fever	☐	☐	Crohn's Disease	☐	☐
Heart Attack	☐	☐	Ulcerative Colitis	☐	☐
Artificial Heart Valve	☐	☐	Stomach Ulcer	☐	☐
Irregular Heartbeat	☐	☐	Arthritis	☐	☐
Phlebitis	☐	☐	Rheumatoid	☐	☐
Anemia	☐	☐	Osteoarthritis	☐	☐
Blood Clots	☐	☐	Artificial joint	☐	☐
Pacemaker	☐	☐	Hepatitis	☐	☐

List any other diseases or conditions ____
List any surgical procedures ____
Have you ever had skin cancer? ☐ Yes ☐ No Type______________________________
Has anyone in your family had skin cancer? ☐ Yes ☐ No Type______________________________
Have you ever had breast cancer? ☐ Yes ☐ No Type______________________________
Has anyone in your family had breast cancer? ☐ Yes ☐ No Type______________________________
Do you have any skin specific diseases? ☐ Yes ☐ No Type______________________________
Do you develop large scars or keloids? ☐ Yes ☐ No
Any bleeding disorders? ☐ Yes ☐ No Type______________________________
Do you develop skin rashes in reaction to medications/foods/bandages? ☐ Yes ☐ No

Social History:
Do you drink alcohol? ☐ Yes ☐ No Drinks per day_____________
Any history of drug abuse or dependency? ☐ Yes ☐ No Type______________________________
Do you smoke or use smokeless tobacco? ☐ Yes ☐ No Amount______________________________
Have you had or have you been exposed to HIV (AIDS)? ☐ Yes ☐ No
(Women) Are you pregnant, or trying to get pregnant? ☐ Yes ☐ No Due Date _____/_____/_____
(Women) Are you nursing ☐ Yes ☐ No
What is your occupation? ______________________________

Patient Signature ______________________________ Date _____/_____/_____

Provider Signature ______________________________ Date _____/_____/_____